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Supreme Court of the United States

PENNSYLVANIA PHARMACISTS ASSOCIATION, BELL-EDGE PHARMACY, BROAD STREET APOTHECARY, BURNS PHARMACY, CAMBRIA PHARMACY #3, CHRISTIAN STREET PHARMACY, ELWYN PHARMACY, ESTERSON PHARMACY, FOSTERS PHARMACY, GETWELL PHARMACY, MCKEAN STREET PHARMACY, ROSICA PHARMACY, S&S COMMUNITY DRUG, INC., SILVERMAN PHARMACY, TIOGA DRUG CO., WELDON PHARMACY, TIRELLI, INC. d/b/a BROAD STREET APOTHECARY, ROBERT SCHREIBER d/b/a BURNS PHARMACY, CAMBRIA PHARMACIES, INC., BARRY JACOBS d/b/a ELWYN PHARMACY, 2401 EAST YORK STREET, INC. d/b/a ESTERSON'S PHARMACY, RIAZ U. RAHMAN d/b/a GETWELL PHARMACY, FOSTER PHARMACY, INC., HAUSSMAN'S PHARMACY, MCKEAN STREET PHARMACY, INC., THOMAS BETTERIDGE d/b/a ROSICA PHARMACY, WELDON PHARMACY, and other similarly situated pharmacies,

Petitioners,

v.

FEATHER O. HOUSTOUN,

Respondent.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Third Circuit

PETITION FOR A WRIT OF CERTIORARI

GREGORY L. LIACOURAS
Counsel of Record
LESLIE H. SMITH
Attorneys for Petitioners
LIACOURAS & SMITH, LLP
1515 Market Street, 9th Floor
Philadelphia, PA 19102
(215) 241-5302

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OR CALL COLLECT (402) 342-2831

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QUESTION PRESENTED

Arising from a conflict between decisions of the United States Court of Appeals for the Third and Fifth Circuits and decisions of the United States Court of Appeals for the First, Seventh and Eighth Circuits, and with this Court's decision in *Wilder v. Virginia Hosp. Assn.*, 496 U.S. 498 (1990), the question presented is whether health care providers may bring actions under 42 U.S.C. § 1983 to challenge the method by which a State reimburses health care providers under Title XIX of the Social Security Act?

LIST OF PARTIES AND RELATED CORPORATIONS

The parties to the proceeding in the United States Court of Appeals for the Third Circuit are the Pennsylvania Pharmacists Association; Bell-Edge Pharmacy; Broad Street Apothecary; Burns Pharmacy; Cambria Pharmacy #3; Christian Street Pharmacy; Elwyn Pharmacy; Esterson Pharmacy; Fosters Pharmacy; Getwell Pharmacy; McKean Street Pharmacy; Rosica Pharmacy; S&S Community Drug, Inc.; Silverman Pharmacy; Tioga Drug Co.; Weldon Pharmacy; Tirelli Inc. d/b/a Broad Street Apothecary; Robert Schreiber d/b/a Burns' Pharmacy; Cambria Pharmacies, Inc.; Barry Jacobs d/b/a Elwyn Pharmacy; 2401 East York Street, Inc. d/b/a Esterson's Pharmacy; Riaz U. Rahman d/b/a Getwell Pharmacy; Foster Pharmacy, Inc.; Haussman's Pharmacy; McKean Street Pharmacy, Inc.; Thomas Betteridge d/b/a Rosica Pharmacy; Weldon Pharmacy, Inc., Plaintiffs-Appellants, and Feather O. Houstoun, in her official capacity as Secretary of the Pennsylvania Department of Public Welfare, Defendant-Appellee.

Pursuant to Rule 29.6, there is no parent or publicly held company owning 10% or more of any Petitioner's stock.

TABLE OF CONTENTS

	Page
Question Presented	i
List of Parties and Related Corporations	ii
Table of Contents	iii
Table of Authorities	iv
Table of Appendices	v
Opinions Below	1
Jurisdiction	1
Statutory & Regulatory Provisions Involved	1
Statement of the Case	3
Reasons for Granting the Writ	7
I. The Import Of The Question Presented	7
II. Conflict Among The Circuits	10
III. Conflict With This Court's Decision In *Wilder*	11
Conclusion	15

TABLE OF AUTHORITIES

Page

CASES:

American Society of Consultant Pharmacists v. Garner, 180 F. Supp.2d 953 (N.D. Ill. 2001) 9

Arkansas Medical Society, Inc. v. Reynolds, 6 F.3d 519 (8th Cir. 1993) 9, 10

Evergreen Presbyterian Ministries, Inc. v. Hood, 235 F.3d 908 (5th Cir. 2000) 7, 10, 11

Florida Pharmacy Ass'n v. Cook, 17 F. Supp.2d 1293 (N.D. Fla. 1998) 9

Methodist Hospitals, Inc. v. Sullivan, 91 F.3d 1026 (7th Cir. 1996) 9, 10

Moody Emergency Med. Serv., Inc. v. City of Millbrook, 967 F. Supp. 488 (M.D. Ala. 1997) 9

Orthopaedic Hospital v. Belshe, 103 F.3d 1491 (9th Cir. 1997), *cert. denied*, 522 U.S. 1044 (1998) 9, 10

Prestera Center for Mental Health Services, Inc. v. Lawton, 111 F. Supp.2d 768 (S.D. W.Va. 2000) 9

Rite Aid of Pennsylvania, Inc. v. Houstoun, 171 F.3d 842 (3d Cir. 1999) 7, 9

Visiting Nurse Ass'n of North Shore, Inc. v. Bullen, 93 F.3d 997 (1st Cir. 1996), *cert. denied*, 519 U.S. 1114 (1997) 9, 10

Wal-Mart Stores, Inc. v. Knickrehm, 101 F. Supp.2d 749 (E.D. Ark. 2000) 9

Wilder v. Virginia Hosp. Ass'n, 496 U.S. 498 (1990) 7, 8, 11, 12, 14

TABLE OF AUTHORITIES – Continued

Page

STATUTES:

42 U.S.C. § 1396a(a)(13)(A) 8, 12

42 U.S.C. § 1396a(a)(30)(A) ..... *passim*

42 U.S.C. § 1983 ..... 1, 5, 8, 10, 14

OTHER AUTHORITIES:

42 C.F.R. § 447.300 6

Pub. L. No. 105-33, § 4711, 111 Stat. 251, 507 (1997) 8

TABLE OF APPENDICES

Appendix A – Opinion Of The United States Court Of Appeals For The Third Circuit Dated And Filed March 13, 2002 ..... 1a

Appendix B – Order Of The United States District Court For The Eastern District Of Pennsylvania Dated And Filed June 7, 2000 ..... 68a

Appendix C – Opinion Of The United States District Court For The Eastern District Of Pennsylvania Dated And Filed June 7, 2000 ..... 69a

Appendix D – Order Of The United States Court Of Appeals For The Third Circuit Dated And Filed July 20, 2001 ..... 92a

Appendix E – Order of the United States District Court For The Eastern District Of Pennsylvania Dated And Filed July 22, 1999 ..... 94a

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

Petitioners respectfully request that the Court grant a writ of certiorari to review the judgment of the United States Court of Appeals for the Third Circuit in this case.

OPINIONS BELOW

The opinion of the Court of Appeals (App. at 1a-67a) is reported at 283 F.3d 531 (3d Cir. 2002). The opinion of the district court (App. 68a-91a) is reported at 2000 U.S. Dist. LEXIS 7807 (E.D. Pa. June 7, 2000).

JURISDICTION

The Court of Appeals for the Third Circuit entered the decision that is the subject of this petition on March 13, 2002. (App. at 2a) The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

STATUTORY & REGULATORY PROVISIONS INVOLVED

42 U.S.C. § 1983 provides:

> Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory or the District of Columbia, subjects, or causes to be subjected, any citizen of the United States or other person within

> the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress, except that in any action brought against a judicial officer for an act or omission taken in such officer's judicial capacity, injunctive relief shall not be granted unless a declaratory decree was violated or declaratory relief was unavailable. For the purposes of this section, any Act of Congress applicable exclusively to the District of Columbia shall be considered to be a statute of the District of Columbia.

Section 1902(a)(30)(A) of Title XIX of the Social Security Act, 42 U.S.C. § 1396a(a)(30)(A) provides that a State plan for Medical Assistance must:

> provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan (including but not limited to utilization review plans provided for in section 1396b(i)(4) of this title) as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.

STATEMENT OF THE CASE

The Pennsylvania Pharmacists Association ("PPA") and sixteen individual pharmacies brought this class action against Feather O. Houstoun, the Secretary of the Pennsylvania Department of Public Welfare (the "Department"), because the outpatient pharmacy Medicaid reimbursement rates set by Health Maintenance Organizations ("HMOs") in Southeastern Pennsylvania have been cut so severely that they fail to reimburse pharmacies for the costs of acquiring and dispensing prescription drugs.

The Commonwealth of Pennsylvania participates in the cooperative federal-state Medicaid program, through which federal funds are made available to States so that States may furnish medical care to needy individuals. Having chosen to participate in the Medicaid program, Pennsylvania must comply with the Medicaid Act, 79 Stat. 343, as amended, 42 U.S.C. § 1396 *et seq.*, and the implementing regulations promulgated by the Secretary of Health and Human Services.

The Department administers the Medicaid program in Pennsylvania. As required by the Medicaid Act, 42 U.S.C. § 1396a(a), the Department has adopted a State Plan for medical assistance. Among other things, Pennsylvania's State Plan addresses reimbursement to be paid to health care providers for services rendered to Medicaid recipients. Petitioners operate retail pharmacies in the Pennsylvania counties of Bucks, Chester, Delaware, Montgomery, and Philadelphia (the "Five County Area") and provide prescription drugs and related professional services to Medicaid recipients. This case involves the

change in the Medicaid system in the Five County Area from fee-for-service to managed care.

Prior to 1997, when Petitioners filled a prescription for a Medicaid recipient, they were reimbursed for their services directly by the Department pursuant to "methods and procedures" incorporated in the State Medicaid Plan to "assure that payments are consistent with efficiency, economy and quality of care and are sufficient to enlist enough providers" to make services available "at least to the extent . . . available to the general population in the geographic region." In 1997, the Department implemented a managed care program in the Five County Area called HealthChoices. In HealthChoices, the Department contracted with four HMOs to administer the Medicaid Program for the Department, and the Department agreed to pay the HMOs on a per-person basis, and to allow the HMOs to set pharmacy reimbursement rates at whatever levels the HMOs see fit. (App. at 32a). The Department entirely removed itself from the rate-setting determinations, deferring completely to the HMOs and eliminating any "methods and procedures" from the State Plan to assure compliance with the requirements of Section 1902(a)(30)(A) of the Medicaid Act, 42 U.S.C. § 1396a(a)(30)(A) ("Section 30(A)").

As could have been expected, the HMOs systematically reduced Medicaid payments to pharmacies in order to cover their administrative costs and maximize their profits, creating a situation whereby the HMOs have squeezed pharmacies and reduced reimbursement rates to levels that are below any reasonable measure of the cost of providing care and services. As noted in Chief

Judge Becker's minority opinion, (App. at 33a-34a), Petitioners produced evidence showing that the current HealthChoices reimbursement rates have: 1) prevented pharmacies from dispensing or stocking certain drugs; 2) forced Medicaid pharmacies to cut back on services; 3) created administrative problems that prevent Medicaid recipients from obtaining medication; 4) forced recipients to repeatedly change their medications, causing delays and leading to health problems when the new medication is ineffective; 5) given rise to restrictive formularies that cause delays in recipients' prescriptions being filled, often to the detriment of recipients' health; 6) led to HMOs making medical judgments on a daily basis over the phone and denying medications they know nothing about; 7) caused 50% of the pharmacies in the Five County Area that participated in Medicaid to drop out since 1997; 8) led to a situation where the privately insured population has access to approximately 50% more pharmacies than Medicaid recipients; and 9) created huge gaps in Medicaid pharmacy coverage where there are no pharmacies that participate in Medicaid in fifteen contiguous zip codes in Bucks and Montgomery counties. The decision by the Court of Appeals that providers do not have a private right to enforce Section 30(A) of the Medicaid Act renders each of these facts irrelevant.

On January 29, 1999, Petitioners filed a complaint in the United States District Court for the Eastern District of Pennsylvania. Proceeding under 42 U.S.C. § 1983, Petitioners alleged that the Department's decision to allow the HMOs to arbitrarily select the reimbursement rates to be paid to Medicaid pharmacies violates Section 30(A)

and the implementing regulations governing Medicaid pharmacy reimbursement at 42 C.F.R. § 447.300 *et seq.*

On July 22, 1999, the District Court denied the Department's Motion to Dismiss the complaint, holding that Petitioners had a private right of action to enforce Section 30(A). On October 21, 1999, the District Court certified a class of pharmacy plaintiffs. On March 24, 2000, after completing discovery, Petitioners and the Department filed cross motions for summary judgment. In support of their motion, Petitioners presented undisputed evidence showing the Department's complete failure to be involved in the selection of pharmacy reimbursement rates in HealthChoices. Petitioners also argued that the Department's decision to remove itself from the rate-setting process was arbitrary, capricious, an abuse of discretion and contrary to federal law and regulations, and that there was no support for the HMOs' decision to reduce pharmacy reimbursement by more than 50%.

On June 7, 2000, the District Court granted summary judgment against Petitioners. On June 20, 2000, Petitioners filed a Notice of Appeal with the United States Court of Appeals for the Third Circuit. Petitioners asked the Court of Appeals to overrule the District Court on the question of a whether the reimbursement rates in HealthChoices violated Section 30(A) and to remand for further proceedings. The Court of Appeals had jurisdiction over Petitioners' appeal pursuant to 28 U.S.C. § 1292(a)(1).

On April 20, 2001, a three-judge panel heard Petitioners' arguments. Prior to the issuance of a panel decision, the Third Circuit granted rehearing *en banc*. (App. at

7a). On March 13, 2002, in a 6 to 5 decision, the Court of Appeals reversed its own decision in *Rite Aid of Pennsylvania, Inc. v. Houstoun*, 171 F.3d 842 (3d Cir. 1999), by affirming the District Court's decision on the alternative ground that pharmacies providing prescription drugs and related services to Medicaid recipients may not enforce the requirements of Section 30(A). (App. at 5a).

REASONS FOR GRANTING THE WRIT

The Court should grant the writ requested in this case to resolve a direct, and growing, conflict between the Circuits with respect to an important question of federal law central to the administration of the cooperative federal-state Medicaid program. The Court should also grant the writ requested in this case to resolve a conflict between the Court's holding, and reasoning, in *Wilder v. Virginia Hosp. Ass'n*, 496 U.S. 498 (1990), and the holding of the Third Circuit in this case, and the Fifth Circuit in *Evergreen Presbyterian Ministries v. Hood*, 235 F.3d 908 (5th Cir. 2000). As explained below, and as the five judge minority in this case observed, with respect to conferring rights on health care providers, there is no principled basis for distinguishing the statutory provision considered by the Court in *Wilder* (*i.e.*, the Boren Amendment) and Section 30(A).

I. The Import Of The Question Presented

Approximately twelve years ago, in a case brought by a hospital association challenging Medicaid reimbursement rates adopted by Virginia, this Court held that

health care providers may bring actions under 42 U.S.C. § 1983 to challenge the method by which a State reimburses health care providers under the Medicaid Act. *See Wilder v. Virginia Hosp. Ass'n*, 496 U.S. at 524. Specifically, this Court concluded that the "Boren Amendment," § 1902(a) of the Medicaid Act, 42 U.S.C. § 1396a(a)(13)(A), created rights enforceable under § 1983. *Id.*

By its terms, the Boren Amendment (repealed in 1997, *see* Pub. L. No. 105-33, § 4711, 111 Stat. 251, 507-08 (1997)), governed reimbursement paid by States to institutional providers such as hospitals and nursing homes. *Id.* at 503. Reimbursement paid by States to non-institutional providers, such as pharmacies, was, and still is, governed by Section 30(A), a separate, but substantially similar, subsection of § 1902a of the Medicaid Act.

Unlike the Boren Amendment, Section 30(A) has not been repealed. Non-institutional providers throughout the United States continue to rely on Section 30(A) as a basis for seeking fair and reasonable compensation for health care provided to Medicaid recipients. When confronted with decisions by state Medicaid agencies regarding Medicaid reimbursement that are arbitrary, capricious and otherwise unlawful, health care providers have initiated actions in federal court seeking to force States to comply with Section 30(A) and the implementing regulations adopted by the Department of Health and Human Services.

Although not always successful, litigation, and the possibility of litigation, commenced by health care providers limits the ability of States to unfairly manipulate

Medicaid reimbursement. *See Arkansas Medical Society, Inc. v. Reynolds*, 6 F.3d 519 (8th Cir. 1993); *Methodist Hospitals, Inc. v. Sullivan*, 91 F.3d 1026 (7th Cir. 1996); *Visiting Nurse Ass'n of North Shore, Inc. v. Bullen*, 93 F.3d 997 (1st Cir. 1996); *Orthopaedic Hosp. v. Belshe*, 103 F.3d 1491 (9th Cir. 1997); *Rite Aid of Pennsylvania, Inc. v. Houstoun*, 171 F.3d 842 (3d Cir. 1999); *American Society of Consultant Pharmacists v. Garner*, 180 F. Supp.2d 953 (N.D. Ill. 2001); *Prestera Center for Mental Health Services, Inc. v. Lawton*, 111 F. Supp.2d 768 (S.D. W.Va. 2000); *Wal-Mart Stores, Inc. v. Knickrehm*, 101 F. Supp.2d 749 (E.D. Ark. 2000); *Florida Pharmacy Ass'n v. Cook*, 17 F. Supp.2d 1293 (N.D. Fla. 1998); *Moody Emergency Med. Serv., Inc. v. City of Millbrook*, 967 F. Supp. 488 (M.D. Ala. 1997).

The decision by health care providers to seek relief in federal court benefits Medicaid recipients as well. The undeniable fact is that the interests of healthcare providers and Medicaid recipients are inextricably intertwined. Given the financial straits of Medicaid recipients and providers' access to information on the relationship between the reimbursement rates and provider participation in Medicaid, healthcare providers may be better able to enforce recipients' and providers' shared interests in assuring that provider reimbursement rates comply with the mandates of Section 30(A). (App. at 31a-32a). As stated by Chief Judge Becker, "although one can find isolated instances of Medicaid recipients suing to enforce Section 30(A), I do not share the majority's optimism that lawsuits brought by Medicaid recipients will provide sufficient enforcement." (App. at 62a) (*citations omitted*).

In this case, the Court of Appeals for the Third Circuit in an *en banc*, 6-5 decision with an emphatic dissent,

joined with the Fifth Circuit in *Evergreen* in concluding that health care providers may not enforce Section 30(A) in an action under § 1983. As a result, health care providers in Pennsylvania, New Jersey, Delaware, Louisiana, Mississippi, and Texas have lost the ability to ensure that state Medicaid agencies comply with the Medicaid Act, leaving the States free to reduce and otherwise manipulate reimbursement paid to providers. Such a situation is particularly troubling when viewed in light of the facts in this case where, in contrast to every other Medicaid case brought under Section 30(A), the State delegated all of its rate-setting duties to private, for-profit entities that have repeatedly slashed the rates paid to pharmacy providers without any basis or justification.

II. Conflict Among The Circuits

The decisions by the Court of Appeals for the Third Circuit in this case and in *Evergreen* are in direct conflict with decisions from the Court of Appeals for the First, Seventh and Eighth Circuits, which hold that providers may pursue a Section 30(A) action under § 1983. *See Visiting Nurse Ass'n*, 93 F.3d at 1004; *Methodist Hospitals, Inc.*, 91 F.3d at 1029; *Arkansas Med. Society, Inc.*, 6 F.3d at 526; *see also Evergreen*, 235 F.3d at 928 (acknowledging that decision conflicts with decisions from the First, Seventh and Eighth Circuits). In addition, the United States Court of Appeals for the Ninth Circuit has affirmed a decision in favor of health care providers brought under § 1983 to enforce the requirements of Section 30(A). *See Orthopaedic Hosp.*, 103 F.3d at 1500.

This conflict involves a threshold issue presented in every suit commenced by health care providers to enforce the Medicaid Act, namely, whether providers may enforce the requirements of the Medicaid Act. The conflict should be resolved, so that the rights of all interested parties will be clear, the Medicaid Act will be uniformly applied throughout the United States, and the ability of health care providers to enforce the Medicaid Act and the implementing federal regulations will not vary from region-to-region. It is not in the public interest for States and providers to litigate for years in multiple jurisdictions only to have the various Circuits reach different conclusions with respect to the threshold question of whether providers may even commence a suit.

III. Conflict With This Court's Decision In *Wilder*

The requested writ should be granted to address the conflict between the decision of the Court of Appeals for the Third Circuit in this case and this Court's decision in *Wilder*. This conflict provides the principal basis for the dissenting opinion of Chief Judge Becker, in which four other members of the Court of Appeals joined. (App. at 29a-65a).

As noted above, this Court in *Wilder* determined that health care providers could enforce the requirements of the now repealed Boren Amendment to the Medicaid Act. With respect to the question that was considered to be dispositive by the Third Circuit in this case and in *Evergreen*, *i.e.*, whether providers are intended beneficiaries, this Court concluded: "There can be little doubt that health care providers are the intended beneficiaries

of the Boren Amendment. The provision establishes a system for reimbursement of providers and is phrased in terms benefiting health care providers: It requires a state plan to provide for 'payment . . . of the hospital services, nursing facility services, and services in an intermediate care facility for the mentally retarded provided under the plan.' " *Wilder*, 496 U.S. at 510 (quoting 42 U.S.C. § 1396a(a)(13)(A) (repealed); omission in original).[1]

Like the Boren Amendment, Section 30(A) speaks in terms of payments to providers, and establishes a system for reimbursement of providers. Although the Boren Amendment has been repealed, Section 30(A) has not. Section 30(A) continues to speak in terms of payments to providers. Consequently, it is reasonable to conclude that this Court's decision in *Wilder* is dispositive of the question of whether providers are among the intended beneficiaries of Section 30(A) and, therefore, that the decision by the Court of Appeals for the Third Circuit in this case is in conflict with this Court's decision in *Wilder*.

The conflict between this Court's decision in *Wilder* and the conclusion that providers are not among the intended beneficiaries of Section 30(A) is summarized by Chief Judge Becker in the dissent in this case:

---

[1] When it revised Section 1902(a)(13)(a) of the Medicaid Act (the former Boren Amendment) in 1997, Congress enacted a public process for the establishment of rates for institutional providers. Congress did not, however, enact any such public process to substitute for the requirements of Section 30(A). The failure of Congress to mandate a public process for the establishment of payments to non-institutional providers reveals the intent by Congress not to eliminate the right of providers to enforce Section 30(A).

Comparing the two statutes [Boren Amendment & Section 30(A)], I can find no principled basis for holding that providers are intended beneficiaries of the Boren Amendment, as the Supreme Court held in *Wilder*, but are not the intended beneficiaries of Section 30(A), as the majority holds today. In particular, I cannot accept the majority's contention that '[t]he language of Section 30(A) contrasts sharply with that of the Boren Amendment.'

Both the Boren Amendment and Section 30(A) require states to reimburse providers for services rendered. *See* Boren Amendment ('A State plan for medical assistance must . . . provide . . . for payment . . . of . . . services . . . provided under the plan. . . . '); Section 30(A) ('A State plan for medical assistance must . . . provide . . . methods and procedures relating to . . . payment for care and services available under the plan. . . . '). And both the Boren Amendment and Section 30(A) define reimbursement rates by reference to efficiency and economy. *See* Boren Amendment (defining rates by reference to 'efficiently and economically operated facilities'); Section 30(A) (requiring states 'to assure that payments are consistent with efficiency [and] economy').

Both the Boren Amendment and Section 30(A) require states to reimburse providers at rates that are sufficient to ensure quality of care. *See* Boren Amendment (requiring that reimbursement rates be 'reasonable and adequate to meet the costs which must be incurred . . . in order to provide care and services in conformity with- . . . quality and safety standards'); Section 30(A) (requiring states 'to assure that payments are

> consistent with . . . quality of care'). And both the Boren Amendment and Section 30(A) require states to reimburse providers at rates that are sufficient to guarantee Medicaid recipients adequate access to healthcare. *See* Boren Amendment (requiring 'rates . . . which . . . are reasonable and adequate to assure that individuals eligible for medical assistance have reasonable access . . . to inpatient hospital services'); Section 30(A) (requiring states 'to assure that payments are . . . sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area').
>
> Thus, far from "contrast[ing] sharply," as the majority contends . . . , the Boren Amendment and Section 30(A) confer on providers nearly identical rights to be reimbursed for services provided and to be reimbursed at a minimum rate that is defined by reference to quality of care and adequate access. . . . This case is therefore squarely controlled by *Wilder*, and I would hold that healthcare providers may bring § 1983 actions to enforce the rights conferred on them by Section 30(A).

(App. at 41a-43a) (citations omitted).

The Court should grant the writ requested in this case to resolve this conflict between the holding of, and reasoning in, *Wilder* and the decision by the Court of Appeals for the Third Circuit that health care providers are not among the intended beneficiaries of Section 30(A).

CONCLUSION

For the reasons set forth above, the Court should grant this petition for writ of *certiorari*.

Respectfully submitted,

GREGORY L. LIACOURAS
Counsel of Record
LESLIE H. SMITH
Attorneys for Petitioner
LIACOURAS & SMITH, LLP
1515 Market Street, 9th Floor
Philadelphia, PA 19102
(215) 241-5302

OPINION OF THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT DATED AND FILED MARCH 13, 2002

UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

No. 00-1898

PENNSYLVANIA PHARMACISTS ASSOCIATION; BELL EDGE PHARMACY; BROAD STREET APOTHECARY; BURNS PHARMACY; CAMBRIA PHARMACY #. 3; CHRISTIAN STREET PHARMACY; ELWYN PHARMACY; ESTERSON PHARMACY; FOSTERS PHARMACY; GETWELL PHARMACY; MCKEAN STREET PHARMACY; ROSICA PHARMACY; S & S COMMUNITY DRUG, INC.; SILVERMAN PHARMACY; TIOGA DRUG COMPANY; WELDON PHARMACY, AND OTHER SIMILARLY SITUATED PHARMACIES; TIRELLI, INC., dba BROAD STREET APOTHECARY; ROBERT SCHREIBER, dba BURNS' PHARMACY; CAMBRIA PHARMACIES, INC.; BARRY JACOBS, dba ELWYN PHARMACY; 2401 EAST YORK STREET, INC., dba ESTERSON'S PHARMACY; RIAZ U. RAHMAN, dba GETWELL PHARMACY; FOSTER PHARMACY, INC.; HAUSSMANN'S PHARMACY; MCKEAN STREET PHARMACY, INC.; THOMAS BETTERIDGE, dba ROSICA PHARMACY; WELDON PHARMACY, INC,

Appellants,

v.

FEATHER O. HOUSTOUN

ON APPEAL FROM THE
UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

(Dist. Court No. 99-cv-00491)
District Court Judge: Ronald L. Buckwalter

Argued April 20, 2001

Before: ALITO, McKEE, and ALARCON, *Circuit Judges.*

Argued *En Banc* November 28, 2001

Before: BECKER, *Chief Judge*, MANSMANN, SCIRICA, NYGAARD, ALITO, ROTH, McKEE, RENDELL, BARRY, AMBRO, and FUENTES, *Circuit Judges*

(Opinion Filed: March 13, 2002)

* * *

OPINION OF THE COURT

ALITO, *Circuit Judge*, with whom Judges NYGAARD, ROTH, BARRY, AMBRO and FUENTES join.

The Pennsylvania Pharmacists' Association[1] and 16 pharmacies operating in southeastern Pennsylvania

1. The Pennsylvania Pharmacists' Association is a non-profit corporation representing over 440 independent pharmacies and over 1,000 pharmacists employed at these pharmacies.

brought this action under 42 U.S.C. § 1983 against Feather O. Houstoun, the Secretary of the Pennsylvania Department of Public Welfare (the "Department"), to challenge the reimbursement rates paid to pharmacies under Pennsylvania's Medicaid program. The plaintiffs claimed that the Department, in administering its HealthChoices Southeast program ("HealthChoices"), was violating provisions of Title XIX of the Social Security Act (the "Medicaid Act"), 42 U.S.C. §§ 1396a(a) — 1396v. The plaintiffs' principal claim was based on 42 U.S.C. § 1396a(30)(A) ("Section 30(A)"). In accordance with its interpretation of prior circuit precedent, the District Court held that the plaintiffs could assert their Section 30(A) claim under § 1983, but the District Court nevertheless granted summary judgment against the plaintiffs. We now hold that the plaintiffs, as Medicaid providers, may not assert their claims under § 1983, and we therefore affirm the order of the District Court on this alternative ground.

I.

Medicaid is a cooperative federal-state program under which the federal government furnishes funding to states for the purpose of providing medical assistance to eligible low-income persons. *See* 42 U.S.C. § 1396; *Rite Aid of Pennsylvania, Inc. v. Houstoun*, 171 F.3d 842, 845 (3d Cir. 1999). If a state chooses to participate in the program, it must comply with the Medicaid Act and implementing regulations promulgated by the Secretary of Health and Human Services ("HHS"). *See Wilder v. Virginia Hosp. Ass'n.*, 496 U.S. 498, 502 (1990). In order to participate, a state must submit a medical assistance plan to the Secretary

of HHS and obtain approval of the plan. *See* 42 U.S.C. § 1396; 42 C.F.R. § 430.10 (2001). With further administrative approval, a state may amend a previously approved plan. *See* 42 C.F.R. § 430.12 (2001). Under the Medicaid Act, a state is required to pay for certain enumerated services and may choose to pay for certain additional services. 42 U.S.C. § 1396a(a)(10)(A); 42 C.F.R. § 440.210 (2001). Pennsylvania includes prescription drugs among its optional services. *See* 42 U.S.C. § 1396d(a)(12); 42 C.F.R. § 440.120(a) (2001).

Until 1997, Pennsylvania compensated participating pharmacists directly under a "fee-for-service" program. Payments to these pharmacies generally consisted of two components: (1) ingredient cost reimbursement and (2) a dispensing fee. Pharmacies were compensated for brand-name drugs based on the "estimated acquisition cost" of the drugs[2] plus a "reasonable" dispensing fee. *See* 42 U.S.C. § 1396(a)(30)(A); 42 C.F.R. § 447.300 *et seq.* Pharmacists were compensated for generic drugs using acquisition cost limits established by HHS plus a reasonable dispensing fee.

In 1997, the Pennsylvania Department of Public Welfare began to implement its HealthChoices program, a mandatory managed care program operated in five counties in the southeastern part of the state pursuant to an HFCA waiver

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2. The "estimated acquisition cost" is the "agency's best estimate of the price generally and currently paid by providers for a drug marketed or sold by a particular manufacturer or labeler in the package size of drug most frequently purchased by providers." 42 C.F.R. § 447.301 (2001).

from certain provisions of the Medicaid Act.[3] The Department contracted with four health management organizations ("HMOs") to administer HealthChoices. Three of the four HMOs administer pharmacy benefits through contracts with pharmacy benefits managers. When an HMO contracts with a pharmacy benefits manager, the HMO and the pharmacy benefits manager set the rates at which pharmacies are reimbursed. The pharmacy benefits manager then contracts directly with the participating pharmacies to provide outpatient pharmacy services to eligible beneficiaries.

In order to participate in HealthChoices, the named pharmacy plaintiffs entered into standardized Medical Assistance Provider Agreements with the Department. The Agreements cover the provision of brand-name and generic prescription drugs to eligible beneficiaries and obligate the Department to reimburse the contracting pharmacies in accordance with state and federal law.

In January 1999, the plaintiffs commenced this action in the United States District Court for the Eastern District of Pennsylvania and requested declaratory and injunctive relief. The plaintiffs' principal claim was that the new payment rates violate Section 30(A), which requires a state Medicaid plan to assure that payments "are consistent with efficiency, economy, and quality of care" and "are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area."

3. The waiver applies to 42 U.S.C. § 1396a(a)(1) (statewide scope), § 1396a(a)(10)(B) (comparability of services), and § 1396a(a)(23) (freedom of choice).

The plaintiffs alleged that the pharmacy benefits managers, without oversight from the Department, had decreased the outpatient pharmacy benefit rates so much that they were below the cost of acquiring and dispensing the drugs.

The District Court certified a class of pharmacy plaintiffs and denied the Department's motion to dismiss the complaint, holding that the plaintiffs had "a private right to enforce [Section 30(A)]." Pennsylvania Pharmacists Ass'n v. Houstoun, No. CIV.A. 99-491 (E.D. Pa. October 21, 1999). As support for its holding on this point, the Court cited a footnote in a prior panel opinion of this Court. *See Rite Aid of Pennsylvania, Inc. v. Houstoun*, 171 F.3d 842, 850 n. 7 (3d Cir. 1999).

The District Court subsequently granted the defendant's motion for summary judgment. *Pennsylvania Pharmacists Ass'n v. Houstoun*, No. CIV.A. 99-491, 2000 WL 730344, at * 1 (E.D. Pa. June 7, 2000). The Court held that the Department, in implementing its new program, had properly considered efficiency, economy, and access to quality pharmacy services, that its procedures were neither arbitrary nor capricious, and that the resulting payment rates did not violate Section 30(A). *Pennsylvania Pharmacists Ass'n*, 2000 WL 730344, at * 3-5.

The Plaintiffs appealed, and their arguments were heard before a regular panel. Under a longstanding practice of our Court, a panel may not overrule another panel decision. A footnote in the panel opinion in *Rite Aid* appeared to hold that a provider may assert a Section 30(A) claim under

§ 1983, but the footnote provided no elaboration.[4] By the time of the panel argument in this case, the other courts of appeals were divided on this issue. Prior to the issuance of a panel decision, we granted rehearing en banc primarily for the purpose of considering the § 1983 issue.

II.

The threshold issue that we must consider is whether the plaintiffs, as Medicaid providers (as opposed to Medicaid recipients), may assert a Section 30(A) claim under 28 U.S.C. § 1983. Section 1983 provides a private right of action against any person who, acting under the color of state or territorial law, abridges "rights, privileges, or immunities secured by the Constitution and laws" of the United States. *See also Maine v. Thiboutot*, 448 U.S. 1, 4 (1980). In order to seek redress under § 1983, a plaintiff "must assert the violation of a federal right," and not merely a violation of federal law. *Golden State Transit Corp. v. City of Los Angeles*, 493 U.S. 103, 106 (1989). Thus, a plaintiff alleging a violation of a federal statute may not proceed under § 1983 unless 1) the statute creates "enforceable rights, privileges, or immunities

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4. The *Rite Aid* panel wrote as follows in footnote 7 of the opinion:

> The Department argues at least in part that Rite Aid and the PPA [Pennsylvania Pharmacists Association] may not sue to enforce [certain] Medicaid regulations as section 30(A) "does not support a private cause of action." Brief at 27. The district court rejected this argument and we agree with this result. *Rite Aid*, 998 F. Supp. at 525-26.

171 F.3d at 850.

within the meaning of § 1983" and 2) Congress has not "foreclosed such enforcement of the statute in the enactment itself." *Wright v. Roanoke Redevelopment and Housing Auth.*, 479 U.S. 418, 423 (1987).

In considering the first of these requirements — that the statute must create an enforceable right, privilege, or immunity — we must determine whether the three conditions identified by the Supreme Court in *Wilder* and *Blessing v. Freestone*, 520 U.S. 329 (1997), are satisfied. First, the provision in question must have been "intend[ed] to benefit the putative plaintiff." *Wilder*, 496 U.S. at 509 (quoting *Golden State Transit Corp.*, 493 U.S. at 106) (brackets added in *Wilder*); *see also Blessing*, 520 U.S. at 340. Second, the right allegedly protected by the statute must not be so "vague and amorphous" that its enforcement would strain judicial competence. *Blessing*, 520 U.S. at 340-41; *Wilder*, 496 U.S. at 509. Finally, the statute must unambiguously impose a binding obligation on the states, *id.*, and thus the provision giving rise to the asserted right must be couched in "mandatory, rather than precatory, terms." *Blessing*, 520 U.S. at 341.

Once these requirements are satisfied — and the existence of a federal right is established — a rebuttable presumption arises that the right is enforceable under § 1983. *Blessing*, 520 U.S. at 341. This presumption may be rebutted by showing that Congress expressly or impliedly foreclosed an action under § 1983. *Id.*; *see also Livadas v. Bradshaw*, 512 U.S. 107, 133 (1994).

III.

A.

In the present case, the focus of our inquiry is the requirement that the provision in question must have been intended to benefit the plaintiffs. *Blessing*, 520 U.S. at 340; *Wilder*, 496 U.S. at 509; *Golden State Transit Corp.*, 493 U.S. at 106; *Wright*, 479 U.S. at 430. It is important to keep in mind that the question whether a statute is intended to benefit particular plaintiffs is quite different from the question whether the statute in fact benefits those plaintiffs[5] or even whether Congress knew that the statute would benefit those plaintiffs. In the present case, it may well be that Section 30(A) in fact benefits pharmacies in some states and that Congress realized this in enacting that provision. For example, if Section 30(A) were not on the books, a state plan might provide lesser access to pharmacy services than Section 30(A) requires. In any such state, Section 30(A) presumably has the effect of increasing drug sales, and these increased drug sales presumably benefit pharmacies — as

5. If the intended-to-benefit requirement could be satisfied simply by showing that a plaintiff *in fact benefits* from the law in question, the requirement would be superfluous. No plaintiff may assert a claim in federal court without establishing Article III standing, and this demands, among other things, that the plaintiff demonstrate "injury in fact." *See, e.g., Lujan v. Defenders of Wildlife*, 504 U.S. 555, 560 (1992). A plaintiff asserting a claim based on an alleged violation of a federal law cannot demonstrate injury in fact unless proper enforcement of the law would benefit the plaintiff. Therefore, if the intended-to-benefit requirement could be met simply by showing that the plaintiff would benefit by proper enforcement, that requirement would add nothing to the injury-in- fact test.

well as drug wholesalers, drug manufacturers, many other businesses (*e.g.*, lessors of pharmacy premises, cleaning service firms retained by pharmacies, trash collection companies retained by pharmacies, private security firms retained by pharmacies), employees of all of these businesses, etc. Congress undoubtedly realizes that federal subsidies have such ripple effects, but it would be outlandish to argue that the *Wilder/Blessing* intended- to-benefit requirement permits all of these businesses and individuals to assert Section 30(A) claims in federal court. Our inquiry, consequently, is quite narrow: did Congress, in enacting Section 30(A), *intend to benefit* providers?

In attempting to answer this question, the Supreme Court has instructed us to pay careful attention to the way in which the statutory provision at issue is framed. In *Cannon v. University of Chicago*, 441 U.S. 677, 689 (1979), the Court wrote that the question whether a statute is enacted for the benefit of a particular class of plaintiffs "is answered by looking to the language of the statute itself." The Court noted the importance of any "right- or duty-creating language" in the statute. *Id.* at 690 n.13. Moreover, in holding that the statute in that case was intended to benefit the plaintiffs, the Court observed that the statute was "phrased in terms of the persons benefited" and was "draft[ed] . . . with an unmistakable focus on the benefited class." *Id.* at 691, 692 n.13. More recently, in *Alexander v. Sandoval*, 121 S. Ct. 1511, 1520 (2001), the Court again commented on the importance of the particular phrasing of a statute in this regard.

While *Cannon* and *Alexander* concerned the implication of a private right of action under a statute, rather than the assertion of a statutory claim under § 1983, the tests applied in these contexts partially overlap,[6] and both tests ask whether the statute at issue was intended to benefit the putative plaintiff or plaintiffs. *See Wright*, 479 U.S. at 432-33 (O'Connor, J., dissenting). Thus, in cases applying the *Wilder/ Blessing* test, the Court has also relied on the terms in which the statute is drafted.

Wilder itself is illustrative. In *Wilder*, a hospital filed a § 1983 action asserting a violation of the now-repealed Boren Amendment to the Medicaid Act, 42 U.S.C. § 1396a(a)(13) (1994) (repealed 1997). The Boren Amendment required a state Medicaid plan to provide a class of providers[7]

6. In determining whether a statute creates an implied right of action, the Supreme Court uses the four-part test of *Cort v. Ash*, 422 U.S. 66 (1975), to determine whether Congress intended to create a private remedy. Under this test, the Court considers (1) whether the plaintiff is within the class " 'for whose especial benefit' the statute was enacted," (2) whether "there is any indication of legislative intent, explicit or implicit, either to create such a remedy or to deny one," (3) whether a private remedy would be "consistent with the underlying purposes of the legislative scheme," and (4) whether "the cause of action [is] one traditionally relegated to state law, in an area basically the concern of the States." *Id.* at 78 (citations omitted). A § 1983 plaintiff need not prove that Congress specifically intended that a particular statutory right be enforceable under § 1983 but instead need only meet the three- part test outlined above. *Wilder*, 496 U.S. at 509 n.9.

7. Namely, hospitals and nursing and intermediate care facilities. *See Wilder*, 496 U.S. at 502 n.2.

with payments that were "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities" that comply with applicable state and federal laws and standards. *Id.* Holding that there was "little doubt" that the Boren Amendment was intended to benefit these providers, the Supreme Court stressed the Boren Amendment's cost-reimbursement language, 496 U.S. at 503, and noted that the Amendment "establishe[d] a system for reimbursement of providers **and** *[was] phrased in terms benefitting health care providers.*" *Wilder*, 496 U.S. at 510 (emphasis added). Thus, the Court relied on language in the Boren Amendment that measured the adequacy of payments in relation to the economics of providers, i.e., their need to cover their reasonable costs. As the Court later emphasized in *Suter v. Artist M.*, 503 U.S. 347, 357 (1992), *Wilder* "took pains to analyze the statutory provisions in detail."

B.

With these standards in mind, we focus on the language of Section 30(A). Section 30(A) provides that a state plan for medical assistance must:

> [P]rovide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan . . . as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent

> that such care and services are available to the general population in the geographic area.

Because this language is — to put it mildly — complex, it is helpful to break it down. Under Section 30(A), a state must provide "methods and procedures." These "methods and procedures" must assure that payments to providers produce four outcomes: (1) "efficiency," (2) "economy," (3) "quality of care," and (4) adequate access to providers by Medicaid beneficiaries.[8]

It seems clear to us that the first two required outcomes — "efficiency" and "economy" — relate to the state program, not providers, *i.e.*, Section 30(A) requires that a state program set payments at levels that make the program efficient and economical.[9] What sort of payments would make a program inefficient and uneconomical? Payments that are *too high.*

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8. We use the phrase "adequate access" simply as shorthand for the statutory requirement that providers be "available under the plan at least to the extent that such care and services are available to the general population in the geographic area." We do not suggest that "adequate access" in the lay sense of the term will or will not meet this statutory requirement.

9. Although the plaintiffs argue that these terms refer to the operation of pharmacies, this does not make sense. Suppose payments to pharmacies were set far above cost. That would not make them inefficient or uneconomical, i.e., "wasteful." Webster's Third New International Dictionary (1971). It would simply make them very profitable. Conversely, suppose payments to pharmacies were set well below costs. That also would not make them inefficient or uneconomical. It would simply make participation in the Medicaid program unprofitable and might lead them to withdraw.

Accordingly, the directive to achieve "efficiency" and "economy" was obviously not intended to benefit providers.

That leaves the directives to provide "quality of care" and adequate access. These directives are "draft[ed] . . . with an unmistakable focus on" Medicaid beneficiaries, not providers. *Cannon*, 441 U.S. at 691. They are "phrased in terms benefiting" Medicaid recipients, *Wilder*, 496 U.S. at 510, and these are the persons that Congress intended to benefit. If Congress had wanted to look after pharmacies, it would hardly have framed Section 30(A) in the terms it chose.

The language of Section 30(A) contrasts sharply with that of the Boren Amendment, which was interpreted in *Wilder* as intended to benefit the relevant providers. As previously noted, the Boren Amendment required a state Medicaid plan to provide payments to providers that were "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities" that comply with applicable state and federal laws and standards. Pub. L. No. 96-499, § 962(a), 94 Stat. 2650 (1980). It was thus "phrased in terms benefitting" providers and measured the sufficiency of payments by reference to the economics of providers. It plainly manifested concern for the economic well-being of providers. Section 30(A), unlike the Boren Amendment, does not demand that payments be set at levels that are sufficient to cover provider costs. Unlike the Boren Amendment, it evinces no direct concern for the economic situation of providers. Instead, it demands that payments be set at levels that are sufficient to meet recipients' needs. It is "phrased in terms benefitting"

recipients, and the adequacy of payments is measured in relation to the health needs of recipients. It manifests concern solely for the well-being of recipients. It is therefore apparent from the statutory language that the intended beneficiaries of Section 30(A) are recipients, not providers.

The principal dissent disagrees with this analysis and maintains that the Boren Amendment and Section 30(A) "confer nearly identical rights on providers." Principal Dissent at 23. The principal dissent makes two principal points. First, it dismisses the significance of the presence in the Boren Amendment and the absence from Section 30(A) of language focusing on provider costs. Second, it argues that quality of care played essentially the same role in the Boren Amendment as it does in Section 30(A). Neither point is well taken.

The language in the Boren Amendment focusing on provider costs is telling because it manifests a clear congressional concern for the economic plight of providers and an intent to benefit them. We are convinced that this statutory language was the basis for the *Wilder* Court's statement that the Boren Amendment was "phrased in terms benefitting" providers. 496 U.S. at 510. The principal dissent interprets this statement to mean simply that the Boren Amendment "required states to establish a scheme for provider reimbursement." *See* Principal Dissent at 24. But if this interpretation were correct, the Supreme Court's full sentence ("The provision establishes a system for reimbursement of providers and is phrased in terms benefitting health care providers") would say exactly the same thing twice ("The provision establishes a system for

reimbursement of providers," 496 U.S. at 510, and "require[s] states to establish a scheme for provider reimbursement," Principal Dissent at 23). We therefore disagree with the principal dissent and believe that the reference to phrasing pertains to the Boren Amendment's cost-reimbursement language.

This cost-reimbursement language is also of particular significance in, to use the principal dissent's phrase, "the dynamic of the real world of healthcare."[10] Principal Dissent at 24. Cost reimbursement schemes[11] are generally favorable to providers and greatly disliked by those required to do the reimbursing.[12] The House Committee Report

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10. In its description of the "real world" "context" of this case, the principal dissent (at 24, 25-26) summarizes the plaintiffs' (but not the defendant's) evidence about the effect of the new rates on access to pharmacies. But (1) the plaintiffs' position is disputed, (2) the District Court, which reached the merits of the access issue, held that the plaintiffs had not adduced sufficient evidence to show that the access requirement was not being met, *Pennsylvania Pharmacists Ass'n*, 2000 WL 730344, at * 6-8, and (3) the principal dissent does not purport to have examined or to reach the merits of this issue. We express no view whatsoever on the merits of this question.

11. Before the Boren Amendment, states, as a practical matter, tended to pay for "the actual costs incurred by hospitals in providing care to Medicaid recipients, regardless of disparities in costs or efficiencies among hospitals." *New Jersey Hosp. Ass'n v. Waldman*, 73 F.3d 509, 511 (3d Cir. 1995) The Boren Amendment replaced this actual-cost-reimbursement scheme with a reasonable-cost-reimbursement scheme. See *id.* at 514-15.

12. The National Governors Association unanimously recommended repeal of the Boren Amendment. *See* 1997 WL

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recommending repeal of the Boren Amendment cited a Congressional Budget Office estimate that its elimination would save $1.2 billion over four years,[13] and the National Governors Association provided even higher estimates.[14] We take no side in the policy debate about cost reimbursement, but we think that it is highly unrealistic to minimize the significance of the presence in the Boren Amendment of cost-reimbursement language. This language was plainly a boon for providers, Congress surely understood its implications, and its inclusion in the Boren Amendment was an unmistakable sign of a congressional desire to benefit providers.

The principal dissent also misinterprets the Boren Amendment as containing a quality-of-care requirement similar to that in Section 30(A). *See* Principal Dissent at 24 (Boren Amendment "mandates minimum reimbursement rates defined by reference to quality of care . . . .") *id.* at 33 (rates must be "sufficient to ensure quality of care"); *id.* at 33 (same). In fact, however, quality of care played a

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8219815 (March 11, 1997) (Testimony of Govs. Miller and Leavitt before Sen. Fin. Comm.); 1996 WL 7135617 (Feb. 21, 1996) (Statement of Govs. Thompson, Miller, Chiles, Engler, Leavitt, and Romer before House Commerce Comm.) ("The Boren amendment and other Boren-like statutory provisions must be repealed. 'One hundred percent reasonable cost reimbursement' must be phased out. . . .").

13. H.R. Rep. 149, 105th Cong., 1st Sess. 547 (1997).

14. *See* 1997 WL 8219815 (March 11, 1997) (Testimony of Govs. Miller and Leavitt before Sen. Fin. Comm.).

decidedly secondary role in the Boren Amendment. Whereas quality of care is a primary benchmark for setting payments in Section 30(A), the Boren Amendment simply provided that reimbursements were to be calculated by reference to the reasonable costs of providers that were operating in compliance with other applicable legal requirements — in the precise language of the Amendment, "with applicable State and Federal laws, regulations, and quality and safety standards. . . ." 42 U.S.C. Section 1396a(a)(13)(A) (repealed 1997). Thus, for example, in determining the reasonable costs of a nursing home, the Boren Amendment looked to nursing homes that were complying with state fire safety laws rather than those that cut costs by doing without fire escapes, smoke detectors, etc. (The principal dissent obscures this point by repeatedly eliding the reference to "State and Federal laws[and] regulations" and referring only to "quality and safety standards." *See* Principal Dissent at 31, 33, 35.)[15]

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15. We also disagree with Judge Rendell's view that Section 30(A) manifests an intent to benefit providers simply because it says that a state plan must provide methods and procedures "relating to the utilization of, and payment for, care and services available under the plan."

First, Judge Rendell's analysis looks at only part of Section 30(A), but we do not think that it is possible to determine whether Section 30(A) was intended to benefit providers or just recipients without looking at the entire provision. Moreover, although Judge Rendell would look at only one part of Section 30(A) in determining whether that provision was intended to benefit providers, we assume that she would look at the rest of the provision in determining whether Section 30(A) meets the next requirement set out in *Wilder* and *Blessing*, *viz.*, that the right allegedly protected by the statute must not be so "vague and amorphous" that its enforcement would strain

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In attempting to point out what we view as the critical differences between the Boren Amendment and Section 30(A), we do not dispute the obvious point that these provisions have other features in common, as the principal

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judicial competence. *Blessing*, 520 U.S. at 340-41; *Wilder*, 496 U.S. at 509. If she did not do so — if she confined her analysis of this question to the portion of the statute that she examines in relation to the intent-to-benefit issue — she would have to conclude that this second requirement cannot be met. If Section 30(A) simply said that a state plan must "provide . . . methods and procedures relating to the utilization of, and the payment for, care and services available under the plan," it would not set out a standard that a court could enforce. The substance of what a state plan must meet is set out in the portion of Section 30(A) that follows, and this part of the provision cannot be ignored. We see no justification for examining only one part of a statute in considering the intent-to-benefit issue and then considering other parts of the statute in considering other prongs of the *Wilder/Blessing* inquiry.

Second, if the mere reference to "payment" in the part of Section 30(A) that Judge Rendell examines were enough to show an intent to benefit providers, it would be virtually impossible to draft a provision requiring a state plan to provide services without creating an entitlement to sue on behalf of the providers who furnish those services. Providers, after all, must be paid, and according to Judge Rendell's position, if a statute makes any mention of "payment," it evidences an intent to benefit providers. It is interesting to apply Judge Rendell's analysis to the current version of 42 U.S.C. § 1396a(a)(13), which replaced the Boren Amendment. One of Congress's main objectives — perhaps its dominant objective — in repealing the Boren Amendment was to take away the right to sue under § 1983, but the provision that replaced the Boren Amendment, refers to the "determination of rates of payment under the [state] plan" and goes on to refer repeatedly to "rates."

dissent points out. For instance, the principal dissent is correct in noting that "[b]oth the Boren Amendment and Section 30(A) require states to reimburse providers for services rendered." Principal Dissent at 32. But as we began by cautioning, the inquiry mandated by *Wilder* and *Blessing* — whether Congress *intended* for Section 30(A) to benefit providers as opposed to simply knowing that providers would be benefitted — calls for us to draw a fine line and to take into account the precise statutory language adopted by Congress. After considering the language of the Boren Amendment and Section 30(A), we remain convinced that there are critical differences and that Section 30(A), unlike the Boren Amendment, was not intended to benefit providers.

C.

We have examined the legislative history of Section 30(A) and have found nothing inconsistent with our reading of the statutory language. The plaintiffs note that when Section 30(A) was originally enacted in 1967, *see* Social Security Amendments of 1967, Pub. L. 90-248, § 237, 81 Stat. 821, 911 (1968), it differed in two respects from the current version: it required a state plan to assure that payments were "not in excess of reasonable charges," and it lacked the adequate access requirement that the current version contains.[16] In 1981, Congress changed these features.

16. As enacted in 1967, it required a state to:

> provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan as may be necessary to safeguard against unnecessary utilization of such care and services

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Nothing in the 1981 amendments suggests that the current version of the statute is intended to benefit providers. On the contrary, the effect of the 1981 amendments was to sharpen the focus on Medicaid beneficiaries. Language referring to providers' charges was removed, and language providing a further protection for beneficiaries was added.

The plaintiffs note, however, that the House Committee Report on the 1981 amendments observed that "in instances where the States or the Secretary fail to observe these statutory requirements, the courts would be expected to take appropriate remedial action." H.R. Rep. No. 158, 97th Cong., 312-13 (1981). This statement certainly suggests that the Committee anticipated that some class of plaintiffs would be able to sue to enforce Section 30(A), but it does not show that the Committee anticipated that Medicaid providers, as opposed to recipients, would be able to do so. It is thus of little value for present purposes.

The plaintiffs rely, finally, on certain HHS regulations that the plaintiffs view as showing that HHS has interpreted Section 30(A) as intended to benefit providers. We have examined these regulations, and we do not believe that they

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> and to assure that payments . . . are not in excess of reasonable charges consistent with efficiency, economy, and quality of care.

This provision originated as a Senate Amendment to the House bill, and the brief discussion of this provision in the Conference Committee report says nothing that has a bearing on the issue before us. *See* Conf. Rep. No. 1030, 90th Cong., 1st Sess. (1967), reprinted in 1967 U.S.C.C.A.N. 3179, 3213 (1967).

evidence any such interpretation. The most pertinent of the current regulations cited by the plaintiffs establish upper limits on what a state program may pay for drugs. *See* 42 C.F.R. §§ 447.301, 447.331-.334 (2001). Section 447.331(b), which applies to brand name drugs duly certified by a physician to be medically necessary for a particular recipient, is illustrative. This provision states that a state agency's payments for such drugs

> must not exceed in the aggregate, payment levels that the agency has determined by applying the lower of the —
>
> (1) Estimate acquisition costs plus reasonable dispensing fees established by the agency; or
>
> (2) Providers' usual and customary charges to the general public

These regulations do not assist the plaintiffs here for the obvious reason that they merely set a ceiling, but no floor, on what providers must be paid. Any payments below the ceiling, no matter how low, would satisfy the regulation. Accordingly, the regulations do not show that the Secretary has interpreted Section 30(A) as intended to benefit providers; nor can they be viewed as themselves intended to benefit providers.[17]

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17. In *South Camden Citizens in Action v. New Jersey Dep't of Envtl. Prot.*, 274 F.3d 771 (3d Cir. 2001), we held that a regulation may invoke a private right of action that Congress created through statutory text but may not create a new right.

In sum, we are convinced that Section 30(A) is not intended to benefit providers and that therefore providers may not assert a Section 30(A) claim under § 1983.

D.

Of the other courts of appeals that have considered the question whether providers may assert a Section 30(A) claim under § 1983, the Fifth Circuit's opinion contains the most thorough analysis of the intended-to-benefit requirement. *See Evergreen Presbyterian Ministries, Inc. v. Hood*, 235 F.3d 908, 928-29 (5th Cir. 2000); *see also Walgreen Co. v. Hood*, 275 F.3d 475 (5th Cir. 2001). In Evergreen Presbyterian Ministries, the Fifth Circuit wrote:

> Section 30(A) . . . focuses on recipients in that it is directly keyed to the recipients' access to medical care, and as a result, the recipients are the direct intended beneficiaries of the section. . . . [I]n contrast to the Boren Amendment, section 30(A) does not create an individual entitlement in favor of any provider. The section benefits recipients by ensuring there is an adequate number of providers in the marketplace. Therefore, it may be true that health care providers as a group are indirectly benefitted by section 30(A) because the section requires that the payments to providers be sufficient to ensure that Medicaid recipients have equal access to medical care. But it cannot be said that section 30(A) necessarily confers upon each provider an individual right to a particular payment because the section does not focus directly on providers.

235 F.3d at 928-29 (emphasis in the original). We agree with the Fifth Circuit's analysis and holding.

Prior to the decision in Evergreen Presbyterian Ministries, the First, Seventh, and Eighth Circuits had held that providers may pursue a Section 30(A) action under § 1983, but we decline to follow these decisions. *See Visiting Nurse Ass'n of North Shore, Inc. v. Bullen*, 93 F.3d 997, 1004 (1st Cir. 1996); *Methodist Hosp., Inc. v. Sullivan*, 91 F.3d 1026, 1029 (7th Cir. 1996); *Arkansas Med. Soc'y, Inc. v. Reynolds*, 6 F.3d 519, 526 (8th Cir. 1993).[18]

In *Arkansas Medical Society*, the Eighth Circuit reasoned as follows:

> The question of whether the Medicaid providers are intended beneficiaries is . . . easily resolved. *Wilder* concluded that institutional providers were intended beneficiaries of the Boren Amendment *because the Amendment concerned their reimbursement. Wilder*, 496 U.S. at 510, 110 S.Ct. at 2517. Similarly, the equal access provision [of Section 30(A)] addresses payment for "care and services" provided by noninstitutional providers. The providers here are beneficiaries for

18. In *Orthopaedic Hosp. v. Belshe*, 103 F.3d 1491 (9th Cir. 1997), the Court held in favor of a hospital that appealed an adverse decision regarding a Section 30(A) claim brought under § 1983. However, the Court's opinion provides no indication that the hospital's right to proceed under § 1983 was challenged, and the Court did not address the issue.

> the same reason that the providers in *Wilder* were beneficiaries.

6 F.3d at 526 (emphasis added).

This analysis pays little attention to the differing terms of the Boren Amendment and Section 30(A) and is thus inconsistent with the reminder in Suter to examine each particular statutory provision "in detail." 503 U.S. at 357. *Arkansas Medical Society* fails to note that the Boren Amendment was keyed to providers' costs, whereas Section 30(A) focuses on the care and services available to recipients. Moreover, while *Arkansas Medical Society* read *Wilder* to mean that the Boren Amendment was intended to benefit providers simply because it "concerned their reimbursement," 6 F.3d at 526, *Wilder* actually relied on the fact that the Boren Amendment "establishe[d] a system for reimbursement of providers and [was] phrased in terms benefitting health care providers." *Wilder*, 496 U.S. at 510 (emphasis added). As we have noted, the same cannot be said of Section 30(A).

In *Methodist Hosp., Inc. v. Sullivan, supra*, the Seventh Circuit held that Medicaid providers may assert Section 30(A) claims under § 1983, but the opinion provides no indication that the Seventh Circuit was presented with the question whether Section 30(A) was intended to benefit providers. Instead, the opinion merely addresses-and rejects-the district court's holding that providers could not sue under Section 30(A) because the term "geographic area"[19] is so

19. As previously noted, Section 30(A) requires that a plan assure that "care and services are available under the plan at least to the extent that such care and services are available to the general population *in the geographic area*." 42 U.S.C. § 1396a(30)(A) (emphasis added).

"vague and amorphous" that its enforcement would strain judicial competence. *Methodist Hosp. v. Indiana Family and Social Services Admin.*, 860 F. Supp. 1309, 1331-33 (N.D. In. 1994).

In *Visiting Nurse Ass'n of North Shore, Inc. v. Bullen*, *supra*, the argument presented to the First Circuit regarding the intended-to-benefit requirement was notably different from the argument presented to us. In *Visiting Nurse Ass'n*, it was argued that Section 30(A), unlike the Boren Amendment, is not intended to benefit providers because Section 30(A) "does not list specific categories of health care providers (e.g., hospitals, nursing facilities, and intermediate care facilities." 93 F.3d at 1004. The First Circuit rejected this attempted distinction and wrote:

> The *Wilder* Court first observed that the statute "is phrased in terms benefitting health care *providers*," and leaves "little doubt that health care *providers* are the intended beneficiaries," then proceeded to *illustrate* how the plain language of the Boren Amendment "establishes a system for reimbursement of providers" through its listing of specific types of health care providers. Nowhere did the Court indicate that the more general term "providers" would not suffice, however, or that a listing of specific types of providers is a *sine qua non* without which a congressional intent to benefit health care providers could not be inferred. As long as the two statutory provisions evince a congressional concern for preserving financial incentives to providers — by ensuring adequate

> reimbursement payment levels — providers are appropriately considered intended beneficiaries. *See Arkansas Med. Soc'y, Inc.*, 6 F.3d at 526.

93 F.3d at 1004 (italics in quotations from *Wilder* added by First Circuit). To the extent that the First Circuit rejected the particular argument advanced to it, its decision has no bearing on the issue we address here. And to the extent that the First Circuit simply adopted the reasoning of *Arkansas Medical Society*, we find that reasoning unpersuasive for the reasons already explained.

After considering all of the decisions of other courts of appeals on the question before us, we agree with the Fifth Circuit's analysis in *Evergreen Presbyterian Ministries*, and we respectfully decline to follow the contrary courts of appeals decisions.

E.

Our conclusion that providers may not assert Section 30(A) claims under § 1983 does not mean that Section 30(A)'s important "quality of care" and access requirements will go unenforced. Not only is HHS responsible for ensuring that state plans are administered in accordance with these requirements, see 42 U.S.C. § 1396c, but Medicaid recipients plainly satisfy the intended-to-benefit requirement and are thus potential private plaintiffs. In other parts of the country, recipients have sued to enforce Section 30(A), and the other courts of appeals have uniformly held that recipients may assert such claims under § 1983. *See Evergreen Presbyterian Ministries*, 235 F.3d at 927; *Visiting Nurses Ass'n*, 93 F.3d

at 1004 n.7; *Arkansas Medical Society*, 6 F.3d at 526. If, as the plaintiffs in this case allege, the rates set under the HealthChoices program are so low that compliance with the "quality of care" and access requirements is threatened, we see no reason to believe that recipients in the affected area of the Commonwealth will not seek legal redress to ensure that these critical mandates are met.

IV.

For the reasons explained above, the order of the District Court is affirmed.

BECKER, *Chief Judge, dissenting*, with whom Judges Mansmann,* Scirica, McKee And Rendell join.

The focus of the majority opinion, quite properly, is on whether Section 30(A) is intended to benefit the provider plaintiffs. To reach the result that it was not, the majority must distinguish the case central to the outcome, *Wilder v. Virginia Hospital Association*, 496 U.S. 498 (1990), which held that the Boren Amendment, a statute that by its express terms required states to establish a scheme for reimbursement of Medicaid healthcare providers, is intended to benefit providers. The majority attempts to do so by reasoning that the Boren Amendment and Section 30(A) "contrast[ ] sharply." Maj. Op. at 11. I disagree, for as I will explain, the two statutes confer nearly identical rights on providers. Hence this case is squarely controlled by *Wilder*, which compels the conclusion that healthcare providers may sue under § 1983 to enforce their rights under Section 30(A). The clear majority of Circuits to address the question whether healthcare providers may sue under § 1983 to enforce their rights under Section 30(A) have resolved that question in the affirmative, and my views are in accord.

As the majority observes, the Boren Amendment and Section 30(A) differ textually insofar as the Boren Amendment's reference to provider costs in its definition of reimbursement rates is absent from Section 30(A). The rationale of *Wilder*, however, renders this difference immaterial, since *Wilder* nowhere relied on the Boren

* The Honorable Carol Los Mansmann participated in the oral argument and joined in this opinion, but died before the opinion could be filed.

Amendment's reference to provider costs in concluding that providers were intended beneficiaries of that statute. Rather, *Wilder* clearly explained that the reason providers were intended beneficiaries of the Boren Amendment is that the provision by its express terms required states to establish a scheme for provider reimbursement. *See Wilder*, 496 U.S. at 510. Similarly, Section 30(A) expressly requires states to establish a system for reimbursing providers for services rendered.

Much of the majority opinion is devoted to explaining why Medicaid recipients are among the intended beneficiaries of Section 30(A). I agree, but a statute can have more than one class of intended beneficiaries and hence the mere fact that Congress intended Section 30(A) to benefit Medicaid recipients has no bearing on whether Congress also intended Section 30(A) to benefit Medicaid providers. By its own terms, Section 30(A) is addressed to both healthcare providers and Medicaid recipients, for, like the Boren Amendment, it expressly requires states to establish a scheme for provider reimbursement and mandates minimum reimbursement rates defined by reference to quality of care and recipients' access to care and services. Hence, *Wilder* controls.

While this brief introduction sets up the analytical core of this opinion, it is deficient to the extent that it lacks context — the dynamic of the real world of healthcare. Unfortunately, so does the majority opinion, which, while commendably terse, is short on "realpolitik." I will therefore supply that broader context, which implicates the relationship between provider costs and the availability of services to

Medicaid recipients. The background of this case is the recent change in the Medicaid system in the five-county Philadelphia metropolitan area from fee-for-service to managed care. The plaintiffs have adduced evidence designed to demonstrate that the HMOs, in administering Medicaid, have squeezed the pharmacies and reduced provider reimbursement rates to levels that, according to the plaintiffs, are below any reasonable measure of the cost of providing care and services. As a practical matter, if the HMOs set provider reimbursement rates too low, providers will simply refuse to render services to Medicaid recipients, and recipients will go without adequate access. In fact, 50% of the pharmacies that participated in Medicaid in the five county area have dropped out since 1997. The plaintiffs also produced evidence that no pharmacy within fifteen contiguous zip codes in Bucks and Montgomery counties participates in Medicaid, and that among those pharmacies in the five-county area that continue to participate in Medicaid, quality of care has suffered as a result of inadequate reimbursement rates.

While the plaintiffs' submissions in this area are contested, and failure to establish that the challenged reimbursement rates violate Section 30(A)'s quality of care and adequate access mandates would be fatal to their case, they demonstrate a nexus between the interests of providers and the interests of recipients, which is recognized by the express terms of Section 30(A). Moreover, given the financial straits of Medicaid recipients and providers' access to information on the relationship between reimbursement rates and provider participation in Medicaid, healthcare providers

may be better able to enforce recipients' and providers' shared interest in assuring that provider reimbursement rates comply with the mandates of Section 30(A).

I thus respectfully dissent from the conclusion that § 1983 does not grant providers a cause of action to sue for violations of Section 30(A). Since the Court has not gone beyond the threshold issue of whether § 1983 grants providers a right of action to enforce Section 30(A), I would reconstitute the original panel so that it may resolve the merits of the Department's summary judgment motion, which requires determining whether plaintiffs have produced sufficient evidence for a reasonable jury to find that the challenged reimbursement rates violate Section 30(A)'s quality of care and adequate access mandates, an issue on which I express no opinion.

I.

The managed care program at issue is HealthChoices, under which the Pennsylvania Department of Public Welfare has contracted with four HMOs to administer the Medicaid program in the five-county area. The Department agrees to pay the HMOs on a per-person basis, and permits the HMOs to set pharmacy reimbursement rates. The plaintiffs allege that the pharmacy reimbursement rates set by the HMOs are below any reasonable estimate of pharmacies' costs, and that unless rates are at least adequate to cover providers' costs, they cannot be consistent with quality of care or sufficient to induce enough pharmacies to participate in Medicaid so that Medicaid recipients have the same access to pharmacies as members of the general population, as is required by Section 30(A).

In support of their claim that current rates are inconsistent with quality of care, the plaintiff pharmacists produced evidence that: (1) low reimbursement rates prevent them from dispensing or stocking certain drugs; (2) low reimbursement rates require them to cut back on services provided to customers, such as counseling customers about how to use their medication; (3) administrative problems with the HealthChoices HMOs prevent their customers from obtaining medication; (4) HealthChoices HMOs force their customers to change repeatedly their medication, causing delays and leading to health problems when the new medication is ineffective; (5) HealthChoices HMOs restrict the formularies that may be used to fill customer prescriptions, causing delays in customers' prescriptions being filled, often to the detriment of customers' health; and (6) HealthChoices HMOs make medical judgments on a daily basis over the phone and deny medications that they know nothing about.

In support of their allegation that the reimbursement rates fall below the minimum rates mandated by Section 30(A)'s access requirement, plaintiffs produced evidence showing a precipitous drop in the number of pharmacies in the five-county area who participate in Medicaid since the inception of HealthChoices. In particular, 50% of the pharmacies that participated in Medicaid have dropped out since 1997. Plaintiffs also produced evidence that the HealthChoices reimbursement rates are the lowest rates in the five-county area, and that whereas the Blue Cross network has 963 participating pharmacies in the five-county area, the four HealthChoices HMOs have only 600, 635, 794, and 864 pharmacies each participating in their networks. Moreover, there are no pharmacies that participate in Medicaid in fifteen

contiguous zip codes in Bucks and Montgomery counties. Consequently, according to the plaintiffs, Medicaid recipients lack access to pharmacies to the same extent as the general population.

Whether this evidence is sufficient to create a triable issue of fact as to whether the current rates violate Section 30(A)'s quality of care and adequate access mandate is, of course, disputed by the Department. My purpose in summarizing this evidence is not to express a view as to whether this evidence is sufficient for plaintiffs' claims to survive summary judgment, but rather to provide concrete evidence of the common interest shared by providers and recipients in enforcing the provider reimbursement rates mandated by Section 30(A).

On its face Section 30(A) is addressed to both healthcare providers and Medicaid recipients, as it expressly requires states to establish a scheme for provider reimbursement and mandates minimum reimbursement rates defined by reference to recipients' quality of care and access to care and services. In particular, Section 30(A) requires states to "provide . . . methods and procedures relating to . . . the payment for[ ] care and services available under the plan" and to reimburse providers at rates that are "consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area."

The House Report on the 1989 amendment to Section 30(A) confirms Congress's recognition that because

healthcare providers' participation in Medicaid is voluntary, Medicaid recipients' access to healthcare will suffer if provider reimbursement rates are too low to induce a sufficient number of providers to participate in Medicaid:

> There is no doubt that Medicaid reimbursement rates have not kept pace with average community rates. . . . The Committee believes that, without adequate payment levels, it is simply unrealistic to expect physicians to participate in the program. . . . [T]he Committee bill would require that Medicaid payments for all practitioners be sufficient to enlist enough providers so that care and service are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.

H.R. Rep. No. 101-247, at 390 (1989), *reprinted in* 1989 U.S.C.C.A.N. 2060, 2116. As the majority notes, Section 30(A)'s legislative history also indicates that Congress intended Section 30(A) to be enforced through private actions. *See* H.R. Rep. No. 158, at 312-13 (1981) ("[I]n instances where the States or the Secretary fail to observe these statutory requirements, the courts would be expected to take appropriate remedial action.").

The evidence we have described illustrates the manner in which the interests of healthcare providers and Medicaid recipients are inextricably intertwined. As we noted in *West Virginia University Hospitals, Inc. v. Casey*, 885 F.2d 11 (3d Cir. 1989); *aff'd on other grounds*, 499 U.S. 83 (1991):

> We recognize, of course, that the primary purpose of medicaid is to achieve the praiseworthy social objective of granting health care coverage to those who cannot afford it. It does not necessarily follow, however, that Title XIX grants substantive rights *only* to medicaid patients. Although the broad purpose of the Medicaid Act as a whole is to help the poor attain medical care, the specific purpose of section 1396a(a)(13)(A) is to assure state compliance with some federal standard of hospital reimbursement. The section sets up a plan for the adequate and reasonable reimbursement of hospitals which serve medicaid patients, and thus hospitals are the section's "beneficiaries." Their interests and the interests of medicaid patients are bonded by a common goal, the delivery of adequate health care by the hospitals to state medicaid patients and the enjoyment of such care by the patients. The interests of both are intertwined and hospitals have a concrete stake in reimbursement in accordance with the federal statute and regulations.

Id. at 20. Against this backdrop, I now turn to the doctrinal question whether § 1983 grants healthcare providers a cause of action to enforce Section 30(A).

II.

Until now, nearly every Circuit to consider the issue has held that whether providers may bring actions under § 1983 to enforce the mandates of Section 30(A) is squarely

controlled by the Supreme Court's decision in *Wilder*, which of course remains binding on this Court unless the Supreme Court overrules it. *See State Oil Co. v. Khan*, 522 U.S. 3, 20 (1997) ("[I]t is this Court's prerogative alone to overrule one of its precedents."). The first Court of Appeals to consider the issue was the Eighth Circuit in *Arkansas Medical Society, Inc. v. Reynolds*, 6 F.3d 519 (8th Cir. 1993), which concluded that Section 30(A) is indistinguishable from the Boren Amendment, which the Supreme Court in *Wilder* held was enforceable by providers under § 1983:

> Our analysis in this case is greatly simplified by the *Wilder* opinion. Although focusing on a different subsection, *Wilder* addressed the same statute facing us in this case. *Suter* urges a careful scrutiny of the exact legislation at issue and *Wilder* has already done that. . . . [T]he equal access provision is very analogous to the Boren Amendment examined in *Wilder*; they are similar not only in function but also in the specific language employed.

Id. at 525. With regard to the particular question whether providers are among the intended beneficiaries of Section 30(A), the Court determined that:

> The question of whether the Medicaid providers are intended beneficiaries is also easily resolved. *Wilder* concluded that institutional providers were intended beneficiaries of the Boren Amendment because the Amendment concerned their reimbursement. Similarly, the equal access

> provision [of Section 30(A)] addresses payment for "care and services" provided by noninstitutional providers. The providers here are beneficiaries for the same reason that the providers in *Wilder* were beneficiaries.

Id. at 526 (internal citations omitted).

The First Circuit and the Seventh Circuit have also easily resolved the issue whether providers may bring § 1983 actions to enforce Section 30(A) by noting that the question is squarely controlled by *Wilder*. In *Visiting Nurse Association of North Shore, Inc. v. Bullen*, 93 F.3d 997 (1st Cir. 1996), the First Circuit concluded that providers are among the intended beneficiaries of Section 30(A) for the same reason that the Supreme Court held that they were among the intended beneficiaries of the Boren Amendment:

> The *Wilder* Court first observed that the [Boren Amendment] "is phrased in terms benefitting health care providers," and leaves "little doubt that health care providers are the intended beneficiaries," then proceeded to illustrate how the plain language of the Boren Amendment "establishes a system for reimbursement of providers" .... As long as the two statutory provisions evince a congressional concern for preserving financial incentives to providers — by ensuring adequate reimbursement payment levels — providers are appropriately considered intended beneficiaries.

Id. at 1004 (emphasis and internal citations omitted). Similarly, the Seventh Circuit observed that because *Wilder* had not been overruled, "*Wilder*'s holding binds us," and consequently held that providers have a private right of action under § 1983 to enforce Section 30(A). *See Methodist Hosps., Inc. v. Sullivan*, 91 F.3d 1026, 1029 (7th Cir. 1996) ("We therefore . . . hold that providers of medical care have a private right of action, derived through § 1983, to enforce § 1396a(a)(30)."). Thus, most courts have found that whether § 1983 grants providers a cause of action to enforce Section 30(A) is an issue that is easily disposed of by *Wilder*. Until now, the only Circuit to hold otherwise is the Fifth Circuit in *Evergreen Presbyterian Ministries, Inc. v. Hood*, 235 F.3d 908 (5th Cir. 2000), which I discuss in Section IV, *infra*.

III.

A.

The majority holds that providers may not sue under § 1983 to enforce Section 30(A) because they are not among the provision's intended beneficiaries.[1] Like most Courts of

1. I disagree with the majority's replacement of the requirement under § 1983 that "Congress must have intended that the provision in question benefit the plaintiff," *Blessing v. Freestone*, 520 U.S. 329, 340 (1997), with the stricter requirement, drawn from an implied right of action case, that the statute must be "draft[ed] . . . with an unmistakable focus on the benefitted class." *Cannon v. Univ. of Chi.*, 441 U.S. 677, 691 (1979). *See* Maj. Op. at 9, 11. The Supreme Court has made clear that:

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Appeals to consider the issue, I believe that the inquiry into whether providers are among the intended beneficiaries of Section 30(A) begins and ends with *Wilder*.

The Boren Amendment, which was the statute that providers sought to enforce in *Wilder*, provided, in relevant part:

> A State plan for medical assistance must . . . provide . . . for payment . . . of hospital services, nursing facilities, and services in an intermediate

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> [Whether a cause of action exists under § 1983] is a different inquiry than that involved in determining whether a private right of action can be implied from a particular statute. In implied right of action cases, we employ the four-factor Cort test to determine whether Congress intended to create the private remedy asserted for the violation of statutory rights. The test reflects a concern, grounded in separation of powers, that Congress rather than the courts controls the availability of remedies for violations of statutes. Because § 1983 provides an alternative source of express congressional authorization of private suits, these separation-of- powers concerns are not present in a § 1983 case.

Wilder, 496 U.S. at 508 n.9 (internal quotations and citations omitted). The Supreme Court has never held that to be enforceable under § 1983, a provision must also be "draft[ed] . . . with an unmistakable focus on the benefitted class," *Cannon*, 441 U.S. at 692, as the majority asserts. Rather, in the § 1983 context, a plaintiff must simply show that the provision in question was "intended to benefit" the plaintiff. *Golden State Transit Corp. v. City of L.A.*, 493 U.S. 103, 106 (1989).

> care facility for the mentally retarded provided under the plan through the use of rates . . . which the State finds . . . are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards and to assure that individuals eligible for medical assistance have reasonable access (taking into account geographic location and reasonable travel time) to inpatient hospital services of adequate quality. . . .

42 U.S.C. § 1396a(a)(13)(A) (repealed). The text of Section 30(A) is strikingly similar. It provides, in relevant part:

> A State plan for medical assistance must . . . provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan . . . as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area . . . .

42 U.S.C. § 1396a(a)(30)(A). Comparing the two statutes, I can find no principled basis for holding that providers are

intended beneficiaries of the Boren Amendment, as the Supreme Court held in *Wilder*, but are not intended beneficiaries of Section 30(A), as the majority holds today. In particular, I cannot accept the majority's contention that "[t]he language of Section 30(A) contrasts sharply with that of the Boren Amendment." Maj. Op. at 11.

Both the Boren Amendment and Section 30(A) require states to reimburse providers for services rendered. See Boren Amendment ("A State plan for medical assistance must . . . provide . . . for payment . . . of . . . services . . . provided under the plan. . . ."); Section 30(A) ("A State plan for medical assistance must . . . provide . . . methods and procedures relating to . . . payment for, care and services available under the plan. . . ."). And both the Boren Amendment and Section 30(A) define reimbursement rates by reference to efficiency and economy. *See* Boren Amendment (defining rates by reference to "efficiently and economically operated facilities"); Section 30(A) (requiring states "to assure that payments are consistent with efficiency [and] economy").

Both the Boren Amendment and Section 30(A) require states to reimburse providers at rates that are sufficient to ensure quality of care. *See* Boren Amendment (requiring that reimbursement rates be "reasonable and adequate to meet the costs which must be incurred . . . in order to provide care and services in conformity with . . . quality and safety standards"); Section 30(A) (requiring states "to assure that payments are consistent with . . . quality of care"). And both the Boren Amendment and Section 30(A) require states to reimburse providers at rates that are sufficient to guarantee

Medicaid recipients adequate access to healthcare. *See* Boren Amendment (requiring "rates . . . which . . . are reasonable and adequate . . . to assure that individuals eligible for medical assistance have reasonable access . . . to inpatient hospital services"); Section 30(A) (requiring states "to assure that payments are . . . sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area").

Thus, far from "contrast[ing] sharply," as the majority contends, *see* Maj. Op. at 11, the Boren Amendment and Section 30(A) confer on providers nearly identical rights to be reimbursed for services provided and to be reimbursed at a minimum rate that is defined by reference to quality of care and adequate access. *See Ark. Med. Soc'y, Inc. v. Reynolds*, 6 F.3d 519, 525 (8th Cir. 1993) ("[T]he equal access provision [of Section 30(A)] is very analogous to the Boren Amendment examined in *Wilder*; they are similar not only in function but also in the specific language employed."). This case is therefore squarely controlled by *Wilder*, and I would hold that healthcare providers may bring § 1983 actions to enforce the rights conferred on them by Section 30(A).[2]

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2. I fully concur in the majority's distinction between "the question whether a statute is intended to benefit particular plaintiffs" and "the question whether the statute in fact benefits those plaintiffs." Maj. Op. at 8. Similarly, I agree with the majority's observation that "lessors of pharmacy premises, cleaning service firms retained by pharmacies, trash collection companies retained by pharmacies, [and] private security firms retained by pharmacies" may all benefit from Section 30(A). Maj. Op. at 8. But I have little

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B.

The majority's rationale relies heavily on the fact that Section 30(A) is addressed in part to recipients, since it defines provider reimbursement rates by reference to quality of care and adequate access. *See* Maj. Op. at 11 ("[Section 30(A)'s] directives to provide 'quality of care' and adequate access. . . . are drafted with an unmistakable focus on Medicaid beneficiaries, not providers."); *id.* at 12 ("[Section 30(A)] demands that payments be set at levels that are sufficient to meet recipients' needs."); *id.* ("[T]he adequacy of payments [under Section 30(A).] is measured in relation to the health needs of recipients."); *id.* at 19 ("Section 30(A) focuses on the care and services available to recipients."); *id.* at 12 ("It is therefore apparent from the statutory language that the intended beneficiaries of Section 30(A) are recipients, not providers.").

To rely on the quality of care and adequate access guarantees as a basis for holding that Section 30(A) was not intended to benefit providers, however, would require overruling *Wilder*, which squarely held that a statute that defines provider reimbursement rates by reference to Medicaid recipients' quality of care and Medicaid recipients' access to care and services may nonetheless be intended to benefit providers. Nowhere in *Wilder* did either the majority

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difficulty in concluding that these third parties are not among the intended beneficiaries of Section 30(A), for the simple reason that Section 30(A) expressly requires states to establish a scheme for reimbursing those who provide healthcare services, not garbage collection services or security services.

or the dissent even hint that the Boren Amendment's reference to quality of care and adequate access should give the Court pause before concluding that the Boren Amendment was intended to benefit providers. As such, for purposes of determining whether providers are intended beneficiaries of Section 30(A), *Wilder* renders irrelevant the fact that Section 30(A) includes quality of care and adequate access guarantees.

Inexplicably, then, the majority makes the adequate access and quality of care guarantees that are found in both the Boren Amendment and Section 30(A) the cornerstone of its analysis in holding that providers are not intended beneficiaries of Section 30(A). To be consistent with *Wilder*, which held that providers are intended beneficiaries of the Boren Amendment, however, a rationale leading to the conclusion that providers are not intended beneficiaries of Section 30(A) must rest not on *similarities* between the Boren Amendment and Section 30(A), as does the vast bulk of the majority opinion, but rather on *differences*.

C.

The *only* difference between the Boren Amendment and Section 30(A) that the majority relies on is the Boren Amendment's reference to providers' costs, which is absent from Section 30(A). For the reasons discussed below, however, the reference to providers' costs in the Boren Amendment and the absence of such a reference in Section 30(A) are immaterial for purposes of determining whether providers are among the intended beneficiaries of Section 30(A).

First, the language of the Boren Amendment did not create any independent right on the part of providers to be reimbursed for their costs without reference to quality of care, as the majority maintains. The majority repeatedly quotes the language in the Boren Amendment requiring payments to be "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities," Maj. Op. at 10, 11, but neglects to quote the remainder of the clause, which goes on to expressly define costs in terms of quality of care. In fact, the Boren Amendment required payment for "the costs which must be incurred by efficiently and economically operated facilities *in order to provide care and services in conformity with* applicable State and Federal laws, regulations, and *quality and safety standards*." (emphases added). The plain language of the Boren Amendment thus explicitly defined "costs" by reference to quality of care, and created no independent right of providers to be reimbursed for their costs beyond that conferred by the quality of care requirement, such as exists in Section 30(A).

I acknowledge that quality of care guarantees in the two statutes are not completely identical — the Boren Amendment requires rates that "meet the costs which must be incurred . . . to provide care and services in conformity with . . . quality and safety standards," while Section 30(A) requires rates that "are consistent with . . . quality of care." I cannot agree with the majority's conclusion, however, that this difference is so significant that quality of care "played a decidedly secondary role in the Boren Amendment," but "is a primary benchmark" in Section 30(A). Maj. Op. at 14. Indeed, the majority never explains how a reimbursement rate could be so low that it

violates the Boren Amendment's requirement that rates meet "the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards," yet nonetheless be "consistent with . . . quality of care," as mandated by Section 30(A).

Even assuming, *arguendo*, that the majority is correct that the Boren Amendment created an independent right on the part of providers to be reimbursed for their costs without reference to quality of care, the plaintiffs in *Wilder* were suing to enforce both their right to be reimbursed at rates that covered their costs, as well as their independent right under the Boren Amendment to be reimbursed at rates that are sufficient to ensure adequate access. *See Wilder*, 496 U.S. at 503 ("Respondent contends that Virginia's Plan for reimbursement violates the Act because the rates are not reasonable and adequate to meet the economically and efficiently incurred cost of providing care to Medicaid patients in hospitals and do not assure access to inpatient care.") (emphasis added and internal quotation marks omitted). Had *Wilder*'s holding rested on the Boren Amendment's reference to provider costs, as the majority contends, then the Court would have permitted the providers to sue under § 1983 to enforce *only* their right to be reimbursed for their costs, and not their additional right under the Boren Amendment to be reimbursed at rates sufficient to ensure recipients adequate access to care and services.

The plain language of § 1983 creates a cause of action not for a violation of a statute as an undifferentiated whole,

but rather for a violation of a "right[ ] . . . secured by the Constitution or laws" of the United States. *See Blessing v. Freestone*, 520 U.S. 329, 340 (1997) ("In order to seek redress through § 1983, . . . a plaintiff must assert the violation of a federal right, not merely a violation of federal law."); *id.* at 342 ("It was incumbent upon the respondents to identify with particularity the rights they claimed, since it is impossible to determine whether Title IV-D, as an undifferentiated whole, gives rise to undefined 'rights.' "). By permitting the providers' suit to proceed, the Supreme Court necessarily held that providers are among the intended beneficiaries of not only the Boren Amendment's requirement that reimbursement rates be sufficient to cover provider costs, but also the Boren Amendment's requirement that reimbursement rates be sufficient to ensure recipients' adequate access to care and services.

Finally, and most importantly, the Supreme Court's rationale in *Wilder* made clear that in concluding that providers were intended beneficiaries of Section 30(A), it was relying not on the Boren Amendment's reference to providers' costs, as the majority asserts, but rather on the Boren Amendment's express requirement that states establish a scheme to reimburse providers for services rendered. In attempting to distinguish Section 30(A) from the Boren Amendment, the majority repeatedly quotes *Wilder*'s conclusion that the Boren Amendment "was phrased in terms benefitting health care providers," *see* Maj. Op. at 10, 12, 20, but conspicuously omits the rest of the sentence, in which the *Wilder* Court explained *why* it concluded that the Boren Amendment "was phrased in terms benefitting health care providers." The remainder of the sentence, which the majority

never fully quotes, makes clear what particular statutory language in the Boren Amendment the Court in *Wilder* was in fact relying on in concluding that the Boren Amendment was "phrased in terms benefitting providers":

> There can be little doubt that health care providers are the intended beneficiaries of the Boren Amendment. The provision establishes a system for reimbursement of providers and is phrased in terms benefitting health care providers: *It requires a state plan to provide for "payment of the hospital services, nursing facility services, and services in an intermediate care facility for the mentally retarded provided under the plan."* 42 U.S.C. § 1396a(a)(13)(A) (1982 ed., Supp. V)

Wilder, 496 U.S. at 510 (internal alterations omitted) (emphasis added).

The majority is "convinced," Maj. Op. at 12, that when the *Wilder* Court stated that the Boren Amendment "is phrased in terms benefitting health care providers: It requires a state plan to provide for 'payment of the hospital services, nursing facility services, and services in an intermediate care facility for the mentally retarded provided under the plan,' " the Court was relying on language in the Boren Amendment other than the language it directly quoted. It is difficult to imagine how a judicial opinion could be more clear about what particular statutory language it is relying on to establish a given proposition than by expressly quoting that language immediately following the proposition, as the Supreme Court did in *Wilder*. The majority's conclusion that the Court quoted

only a portion of the statutory language that it relied on in concluding that the Boren Amendment was "phrased in terms benefitting health care providers" is particularly puzzling given that, according to the majority, that portion of the Boren Amendment that the Court *actually* quoted in the passage above was insufficient to establish the proposition for which it was cited, while that portion of the Boren Amendment that the Court *neglected* to quote (the Boren Amendment's reference to provider costs) was, according to the majority, "plainly a boon for providers," and "an unmistakable sign of a congressional desire to benefit providers." Maj. Op. at 14.

Indeed, by the majority's reasoning, it is hard to see why the *Wilder* majority, in concluding the Boren Amendment was "phrased in terms benefitting health care providers," would even bother to quote the particular language in the Boren Amendment requiring "payment of the hospital services, nursing facility services, and services in an intermediate care facility for the mentally retarded provided under the plan," given that, according to the majority, the nearly identical language in Section 30(A) requiring "payment for [ ] care and services available under the plan," "manifests concern solely for the well-being of recipients." Maj. Op. at 12 (emphasis added).[3]

3. The majority attempts to overcome the obvious difficulty posed by the *Wilder* Court's quotation of the particular language in the Boren Amendment that it was relying on by invoking the canon of construction that a statute should be construed to avoid rendering any part of it superfluous. According to the majority, if the reason that *Wilder* concluded that the Boren Amendment was "phrased in terms benefitting health care providers" was that it required a state plan to provide for "payment of the hospital services, nursing facility (Cont'd)

Given that the excerpt quoted above contains the *Wilder* Court's *entire* discussion of whether providers were intended

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services, and services in an intermediate care facility for the mentally retarded provided under the plan" (the language in the Boren Amendment that the *Wilder* majority relied on), then the Supreme Court's "full [sic] sentence ('The provision establishes a system for reimbursement of providers and is phrased in terms benefitting health care providers') would say exactly the same thing twice. . . ." Maj. Op. at 12.

I believe that this reasoning errs by "minutely parsing phrases, and seeking shades of meaning in the interstices of sentences and words, as though a discursive judicial opinion were a statute." *Schlup v. Delo*, 513 U.S. 298, 343 (1995) (Scalia, J., dissenting). Even if the majority were correct that my reading of *Wilder* renders a portion of a sentence in the opinion redundant, it would be neither the first nor the last time that a judicial opinion sought clarity at risk of redundancy. Whatever redundancy might exist in the sentence at issue in *Wilder*, I nonetheless believe that the Court was relying on the statutory language that it quoted when it stated that the Boren Amendment "is phrased in terms benefitting health care providers: It requires a state plan to provide for 'payment of the hospital services, nursing facility services, and services in an intermediate care facility for the mentally retarded provided under the plan.' "

At all events, the Supreme Court's statement that the Boren Amendment "establishes a system for reimbursement of providers" and the Supreme Court's conclusion that the Boren Amendment "is phrased in terms benefitting health care providers" because it "requires a state plan to provide for 'payment of the hospital services, nursing facility services, and services in an intermediate care facility for the mentally retarded provided under the plan' " do not amount to "say[ing] exactly the same thing twice." Maj. Op. at 12. The first

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beneficiaries of the Boren Amendment, the majority is plainly incorrect when it asserts that "the Supreme Court [in *Wilder*] stressed the Boren Amendment's cost-reimbursement language," and that "the Court *relied* on language in the Boren Amendment that measured the adequacy of payments in relation to the economics of providers, i.e., their need to cover their reasonable costs." Maj. Op. at 10 (emphases added). Nowhere in its analysis did the Court rely on the Boren Amendment's reference to provider costs, much less "stress" such language, as the majority contends. And whatever this Court may think about the breadth of the Supreme Court's rationale, it is not our function to rewrite a Supreme Court opinion to narrow its holding by imputing to the Court reliance on a fact that played no role in the Court's rationale. Rather, the scope of the *Wilder* Court's holding must be determined by reference to the *Wilder* Court's *ratio decidendi* as articulated by the *Wilder* Court.

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statement is addressed to the *substance* of the Boren Amendment (the Boren Amendment "establishes a system for reimbursement of providers," 496 U.S. at 510); the second statement is addressed to the Boren Amendment's *text* (the Boren Amendment "is phrased in terms benefitting health care providers: It requires a state plan to provide for 'payment of the hospital services, nursing facility services, and services in an intermediate care facility for the mentally retarded provided under the plan.' " 496 U.S. at 510). *See* Maj. Op. at 9 (commenting on "the importance of the particular phrasing of a statute in this regard"); Maj. Op. at 16 ("[T]he inquiry mandated by *Wilder* and *Blessing* — whether Congress *intended* for Section 30(A) to benefit providers as opposed to simply *knowing* that providers would be benefitted — calls for us . . . to take into account the precise statutory language adopted by Congress.").

As is readily apparent from the analysis quoted above, the *Wilder* Court made perfectly clear that in concluding that "there can be little doubt that healthcare providers are the intended beneficiaries of the Boren Amendment," it was relying on the language in the Boren Amendment requiring a state plan to provide for "payment of the hospital services, nursing facility services, and services in an intermediate care facility for the mentally retarded provided under the plan." *See Ark. Med. Soc'y, Inc. v. Reynolds*, 6 F.3d 519, 526 (8th Cir. 1993) ("*Wilder* concluded that institutional providers were intended beneficiaries of the Boren Amendment because the Amendment concerned their reimbursement."); *see also Evergreen Presbyterian Ministries, Inc. v. Hood*, 235 F.3d 908, 925 (5th Cir. 2000) ("[T]he [*Wilder*] Court concluded that there was little doubt that the providers were the intended beneficiaries of the Boren Amendment because it established a system for reimbursement of providers and was phrased in terms benefitting health care providers, in that it required a state plan to provide for their payment.") (internal quotations and alterations omitted); *Visiting Nurse Ass'n of N. Shore, Inc. v. Bullen*, 93 F.3d 997, 1004 (1st Cir. 1996) ("The *Wilder* Court . . . observed that the statute 'is phrased in terms benefitting health care providers,' and . . . then proceeded to illustrate how the plain language of the Boren Amendment 'establishes a system for reimbursement of providers .' ") (emphasis omitted).

Thus, for the same reason that the *Wilder* Court concluded that the Boren Amendment was "phrased in terms benefitting health care providers: It requires a state plan to provide for 'payment of the hospital services, nursing facility

services, and services in an intermediate care facility for the mentally retarded provided under the plan,' " 496 U.S. at 510 (quoting the Boren Amendment), I would conclude that Section 30(A) is phrased in terms benefitting health care providers: It requires a state plan to provide for "payment for[ ] care and services available under the plan." *See Ark. Med. Soc'y*, 6 F.3d at 526 ("[T]he equal access provision [of Section 30(A)] addresses payment for 'care and services' provided by noninstitutional providers. The providers here are beneficiaries for the same reason that the providers in *Wilder* were beneficiaries."); *Visiting Nurse Ass'n*, 93 F.3d at 1004 (1st Cir. 1996) ("As long as the two statutory provisions evince a congressional concern for preserving financial incentives to providers — by ensuring adequate reimbursement payment levels — providers are appropriately considered intended beneficiaries.").[4]

4. One further point needs to be made-that the majority's departure from *Wilder* creates serious line-drawing problems. Whereas *Wilder* held that any statute that expressly requires states to pay providers is intended to benefit providers, the majority holds that whether such a statute is intended to benefit providers depends on how the statute defines the minimum payment rate. But the majority never offers an analytically sound explanation of how we are to distinguish those payment floors that are intended to benefit providers from those payment floors that are not.

At times, the majority appears to rely on the fact that the payment floor mandated by Section 30(A) is not expressly defined by reference to provider costs or provider economics. *See* Maj. Op. 12 (distinguishing *Wilder* on the ground that the Boren Amendment "measured the sufficiency of payments by reference to the economics of providers"); *Id.* at 12 ("Unlike the Boren Amendment, [Section 30(A)] evinces no direct concern for the economic situation of (Cont'd)

In sum, although there are differences between the specific language of the Boren Amendment and the specific

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providers."). But if the majority's test of whether providers are intended beneficiaries of a statute requiring states to pay providers some minimum amount turns on whether the language of the statute expressly defines the minimum reimbursement rate by reference to provider costs or provider economics, then providers would not be among the intended beneficiaries of a statute that required states to pay pharmacies $2,500 each time they dispense a given dosage of a particular prescription drug, but would be among the intended beneficiaries of a statute that required states to pay providers 1% of their costs each time they dispensed a drug. In my view, this taxonomy is unreasonable.

Elsewhere, the majority appears to rely on the fact that the text of Section 30(A) defines the minimum reimbursement rates *solely* by reference to the health needs of recipients. *See* Maj. Op. at 12 (observing that under Section 30(A), "the adequacy of payments is measured in relation to the health needs of recipients"). But if the majority's test of whether providers are intended beneficiaries of a statute requiring states to pay providers is whether the statute's language expressly defines reimbursement rates solely by reference to the health needs of recipients, then that test too, produces unreasonable results. Under such a test, providers would not be among the intended beneficiaries of a statute whose language expressly required states to pay providers ten times the rate needed to ensure Medicaid recipients quality of care and adequate access, but providers would be intended beneficiaries of a statute whose language expressly required states to pay providers a dollar every time they filled a Medicaid prescription.

Finally, it may be that the minimum reimbursement rates actually mandated by the Boren Amendment were *lower* than the actual minimum rates mandated by Section 30(A). For example, the Boren
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language of Section 30(A), as there inevitably will be between any two statutes, these differences are immaterial in light of *Wilder*'s rationale, and the Supreme Court in *Wilder* gave no indication that its rationale was "good for this day and train only." *County of Washington v. Gunther*, 452 U.S. 161, 183 (1981) (Rehnquist, J., dissenting).

IV.

Until now, the only Court of Appeals to hold that providers may not bring § 1983 actions to enforce their rights under Section 30(A) was the Fifth Circuit in *Evergreen Presbyterian Ministries, Inc. v. Hood*, 235 F.3d 908 (5th Cir. 2000), which I would decline to follow. In holding that providers are not among the intended beneficiaries of Section 30(A), the Fifth Circuit in Evergreen relied heavily on the Supreme Court's decision in *Blessing v. Freestone*, 520 U.S. 329, 340 (1997), which held that a plaintiff may

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Amendment's access requirement mandated that rates be sufficient to ensure only that "individuals eligible for medical assistance have reasonable access," whereas Section 30(A) requires equal access — rates must be "sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area." Fortunately, *Wilder* avoided the problem of distinguishing those mandatory payment floors that are intended to benefit the payee from those that are not. While how high the statute sets the payment floor will determine the magnitude of the intended benefit (a low minimum reimbursement rate obviously does not benefit providers as much as a high minimum reimbursement rate), under *Wilder* as long as the statute expressly requires states to pay providers, providers are intended beneficiaries.

sue under § 1983 for a violation of a federal statute only if the statute creates an individual entitlement, and not simply a systemwide guarantee. *Id.* at 343. In Blessing, the plaintiffs were mothers whose children were eligible to receive child support services from the state pursuant to Title IV-D of the Social Security Act. *Id.* at 332. Plaintiffs brought a § 1983 action seeking to enforce 42 U.S.C. § 609, which authorizes the Secretary of the Department of Health and Human Services to penalize a state if it is not in "substantial compliance" with Title IV-D. *Id.* at 335.

The *Blessing* Court held that § 609(a)(8) does not create an individual right, enforceable under § 1983, to have states achieve substantial compliance with Title IV-D. First, the Court noted that the plaintiffs had failed to identify a particular provision of Title IV-D that grants them an individual entitlement, and may not simply sue to enforce substantial compliance with Title IV-D as a whole. *See Blessing*, 520 U.S. at 342 ("It was incumbent upon respondents to identify with particularity the rights they claimed, since it is impossible to determine whether Title IV-D, as an undifferentiated whole, gives rise to undefined 'rights.' "). Second, the Court reasoned that because § 609(a)(8)'s "substantial compliance" requirement would be satisfied if the state provided the mandated services in only 75% of the cases reviewed during the federal audit period, "even when a State is in 'substantial compliance' with Title IV-D, any individual plaintiff might still be among the 10 or 25 percent of persons whose needs ultimately go unmet." *Id.* at 344. Thus, "[f]ar from creating an *individual* entitlement to services, the standard [which plaintiffs seek to enforce under § 1983] is simply a yardstick for the

Secretary to measure the *systemwide* performance of a State's Title IV-D program." *Id.* at 343.

In view of the Supreme Court's rationale in *Blessing*, plaintiffs' claims in this case are easily distinguishable from plaintiffs' claims in *Blessing*. First, unlike the plaintiffs in Blessing, the plaintiffs in this case have identified with particularity the right claimed, since they allege that the reimbursement rates violate Section 30(A)'s quality of care and adequate access mandates. *Cf. Blessing*, 520 U.S. at 342 (distinguishing *Wilder* on the ground that "in *Wilder*, we held that health care providers had an enforceable right to reimbursement . . . as required by a particular provision in the Medicaid statute") (emphasis added). This case is therefore distinguishable from *Blessing* for the same reason that the *Blessing* Court concluded that *Wilder* was distinguishable from *Blessing*.

Blessing is further distinguishable on the ground that in that case, the plaintiffs would not necessarily have obtained any benefit had they succeeded on the merits of their claim, since the provision that they sought to enforce under § 1983 required only "substantial compliance" with Title IV-D. *See Blessing*, 520 U.S. at 344 ("[E]ven when a State is in 'substantial compliance' with Title IV-D, any individual plaintiff might still be among the 10 or 25 percent of persons whose needs ultimately go unmet."). By contrast, in this case each individual plaintiff will necessarily benefit if they succeed on the merits, since they would each be individually entitled to reimbursement at higher rates.

I therefore disagree with *Evergreen*'s reliance on *Blessing* in concluding that Section 30(A) creates only a system-wide guarantee, not an individual entitlement on the part of providers. The Fifth Circuit in Evergreen illustrated its reasoning with the following example:

> Assume we have a nursing home in Baton Rouge with 150 residents, which, following the [rate reduction at issue], is forced into bankruptcy and then liquidation. Assume further that the district court decides that the relevant geographic market to measure the access of recipients is the Baton Rouge market for nursing home care and also that the district court concludes that the recipients are entitled to the same access to nursing home care in Baton Rouge as that of non-Medicaid recipients. Finally, assume that, once the nursing home closes, all 150 residents are able to fill vacant beds in other facilities in Baton Rouge. Under this scenario, there is no violation of the recipients' equal access rights, despite the fact that the bankrupt nursing home was put out of business.
>
> From this example, it is apparent that while recipients have an individual entitlement to equal access to medical care, any benefit to healthcare providers is indirect at best. The statute does not confer any direct right upon the individual provider because, as the above example illustrates,

> even if an individual provider is forced to liquidate, the recipients' right to access is not necessarily violated.

235 F.3d at 929. I find this reasoning unpersuasive.

First, the Fifth Circuit put the rabbit in the hat when it reasoned from a hypothetical example in which Section 30(A) is not violated. *See Evergreen*, 235 F.3d at 929 ("Under this scenario, there is no violation of the recipients' equal access rights. . . ."). Of course providers will have no individual entitlement under Section 30(A) to increased reimbursement rates under a factual scenario in which Section 30(A) is not violated. But in a factual scenario where reimbursement rates are so low that Section 30(A)'s adequate access guarantee is violated, every provider who participates in Medicaid would be individually entitled to reimbursement at the higher rate mandated by Section 30(A).

Second, *Evergreen* incorrectly assumed that unless a statute requiring providers to be reimbursed at a given rate ensures that no providers will ever be put out of business, the statute does not create any direct right on the part of providers. *See Evergreen*, 235 F.3d at 929 ("The statute does not confer any direct right upon the individual provider because, as the above example illustrates, even if an individual provider is forced to liquidate, the recipients' right to access is not necessarily violated."). Under any statute addressed to provider reimbursement, however, it will almost always be the case that some providers may go out of business notwithstanding the statute. But this possibility does not mean that the statute creates no individual entitlement on the part of providers.

Consider, for example, a statute that expressly requires states to reimburse pharmacies at least $25 each time they dispense a given dosage of a particular prescription drug to a Medicaid recipient. A $25 reimbursement rate might force certain providers out of business, but it is hard to imagine a statute that more directly confers an individual entitlement on providers. Similarly, there was no guarantee in the Boren Amendment that no provider would ever be put out of business, but the Court in *Wilder* nonetheless held that the Boren Amendment conferred on providers rights that are enforceable under § 1983.

Finally, the *Evergreen* Court mistakenly reasoned that because the minimum reimbursement rate mandated by Section 30(A) is defined by reference to the market-wide criterion of Medicaid recipients' access to healthcare, it does not confer an individual entitlement on providers. *See Evergreen*, 235 F.3d at 928 ("Section 30(A) does *not* create an individual entitlement in favor of any provider. The section benefits recipients by ensuring there is an adequate number of providers in the market place."). That Section 30(A) defines the mandatory minimum provider reimbursement rate by reference to the number of providers in the market place, however, does not make the rate any less mandatory or any less of a minimum. As long as a statute expressly requires providers to be reimbursed at rates that are at least equal to a defined minimum, then the statute creates an individual entitlement on the part of every provider to be reimbursed at that minimum, regardless whether the minimum is defined by reference to providers' costs, recipients' access, quality of care, market rates, or a fixed sum.

Thus, contrary to the Fifth Circuit's conclusion that "it cannot be said that section 30(A) necessarily confers upon each provider an individual right to a particular payment," Section 30(A) clearly does confer upon each provider an individual right to be paid at rates that are at least equal to the statutory minimum. *See Wilder*, 496 U.S. at 510 ("There can be little doubt that health care providers are the intended beneficiaries of the Boren Amendment. The provision establishes a system for reimbursement of providers and is phrased in terms benefitting health care providers: It requires a state plan to provide for 'payment of the hospital services, nursing facility services, and services in an intermediate care facility for the mentally retarded provided under the plan.' ") (internal alterations omitted). *Cf. W. Va. Univ. Hosps., Inc. v. Casey*, 885 F.2d 11, 21 (3d Cir. 1989), *aff'd on other grounds*, 499 U.S. 83 (1991) ("Who else is more aggrieved by the absence of an adequate or reasonable hospital reimbursement rate than a disadvantaged hospital and who has a more compelling interest to press for a correction?").

V.

Finally, although one can find isolated instances of Medicaid recipients suing to enforce Section 30(A), *see, e.g.*, *Evergreen Presbyterian Ministries, Inc. v. Hood*, 235 F.3d 908, 931-32 (5th Cir. 2000); *Ark. Med. Soc'y, Inc. v. Reynolds*, 6 F.3d 519, 522 (8th Cir. 1993), I do not share the majority's optimism that lawsuits brought by Medicaid recipients will provide sufficient private enforcement. *See* Maj. Op. at 21-22 ("If, as the plaintiffs in this case allege, the rates set under the HealthChoices program are so low that compliance with the 'quality of care' and access

requirements is threatened, we see no reason to believe that recipients in the affected area of the Commonwealth will not seek legal redress to ensure that these critical mandates are met."). Medicaid recipients are, by definition, people facing severe financial hardship, and therefore are unlikely to have the same access to legal services as healthcare providers.[5]

Moreover, Section 30(A), by its express terms, uses provider reimbursement rates as the means of ensuring recipients' quality of care and adequate access, and healthcare providers are more likely than Medicaid recipients to possess information about the relationship between current provider reimbursement rates and recipients' quality of care and access to care and services. Indeed, few if any Medicaid recipients will even be aware of current provider reimbursement rates, much less have an idea of how a particular rate compares with provider costs and the reimbursement rates offered by non-Medicaid healthcare plans. Nor are Medicaid recipients likely to have ready access to statistical information on the

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5. To be sure, attorney's fees are available to a successful § 1983 plaintiff. *See* 42 U.S.C. § 1988 ("In any action or proceeding to enforce a provision of section[ ] . . . 1983 . . . of this title, . . . the court, in its discretion, may allow the prevailing party . . . a reasonable attorney's fee as part of the costs. . . ."). Awards of attorney's fees may be inadequate to induce attorneys to represent Medicaid recipients in Section 30(A) cases, however, since such attorneys would assume the risk of earning no fees if the lawsuit is unsuccessful. *See City of Burlington v. Dague*, 505 U.S. 557 (1992) (holding that in determining the reasonableness of attorney's fees under federal fee shifting statutes, courts may not enhance the fee award above the "lodestar" amount to compensate attorneys for assuming the risk of receiving no payment for their services if the lawsuit failed).

extent to which healthcare is available to the general public, for purposes of determining whether current reimbursement rates comply with Section 30(A)'s adequate access mandate. By contrast, professional associations such as the pharmacists association plaintiff in this case are more likely to possess the market data necessary to determine whether a colorable claim under Section 30(A) exists.

In sum, because Section 30(A) is expressly addressed to the financial incentives of healthcare providers to participate in Medicaid, healthcare providers are well-situated to vindicate recipients' and providers' shared interest in ensuring that provider reimbursement rates are consistent with quality of care and sufficient to guarantee Medicaid recipients access to care and services to the same extent as the general public. These practical considerations further support the result compelled by *Wilder*.

VI.

Because I believe that the question whether providers may bring § 1983 actions to enforce Section 30(A) is squarely controlled by *Wilder*, I would decline to follow *Evergreen Presbyterian Ministries, Inc. v. Hood*, 235 F.3d 908 (5th Cir. 2000), and would join those Circuits that, relying on *Wilder*, have permitted providers to bring such claims. *See Visiting Nurse Ass'n of N. Shore Inc. v. Bullen*, 93 F.3d 997, 1005 (1st Cir. 1996) ("[W]e conclude that plaintiffs possess standing . . . to enforce section 1396a(a)(30). . . ."); *Methodist Hosps., Inc. v. Sullivan*, 91 F.3d 1026, 1029 (7th Cir. 1996) ("We therefore . . . hold that providers of medical care have a private right of action, derived through

§ 1983, to enforce § 1396a(a)(30)."); *Ark. Med. Soc'y, Inc. v. Reynolds*, 6 F.3d 519, 528 (8th Cir. 1993) ("[T]he equal access provision [of Section 30(A)] may be enforced by Medicaid recipients and providers using 42 U.S.C. § 1983."). I thus respectfully dissent.

To hold as have these other Courts would not of course be the end of the case, for the plaintiffs would still have significant hurdles in the next phase. In particular, plaintiffs would have to demonstrate that they have produced sufficient evidence for a reasonable jury to find that the current reimbursement rates are so low that they violate either the quality of care or adequate access mandate contained in Section 30(A), a question on which I express no opinion here. Since the Court has not gone beyond the threshold issue of whether § 1983 grants providers a right of action to enforce Section 30(A), I would reconstitute the original panel so that it may resolve the merits of the Department's summary judgment motion, which requires determining whether plaintiffs have produced sufficient evidence for a reasonable jury to find that the challenged reimbursement rates violate Section 30(A)'s quality of care and adequate access mandates.

RENDELL, *Circuit Judge*, dissenting, with whom Chief Judge BECKER joins.

I join in Chief Judge Becker's thoughtful dissenting opinion and write separately only to offer a permissible reading of the statutory language different from that urged by the majority. The majority terms the language "complex" and "breaks it down." However, I see it as fairly straightforward — at least regarding what we need to decide — when properly parsed. If we were to "parse" the statute at issue in grammarian fashion, we would note that the "state plan" is the noun, "must provide," the verb, and "methods and procedures," the object. Then comes the descriptive phrase "*relating to the utilization of, and payment for, care and services available under the plan*." The methods and procedures must relate to the use of care and services — by individual recipients — and the *payment* — to providers — for care and services.

What then follows in the statute — preceded by "as may be necessary . . ." — is no more than a further descriptive phrase setting forth the barometer or standard against which the utilization and payment methods and procedures are to be measured. Why should only the *users* be able to challenge a plan that must pass muster not only in terms of the methods and procedures for "utilization," but also the methods and procedures for "payment?"

I think it eminently reasonable to conclude that both aspects — use and payment — are foci, and that both constituencies can speak to whether the statutory requirement ("as may be necessary to . . .") has been fulfilled, and both should have the right to complain that in fact it has not.

Also, in response to the majority's footnote 15, I submit that I am not ignoring the second part of the provision, and I do not view the provision as hopelessly vague. Rather, I see no need to mention it because it sets forth a standard that is quite susceptible to proof. I have little difficulty imagining the gist of the testimony of recipients, providers, and state administrators as to how the procedures in place impact the sufficiency of payment and quality of service, so that judicial decision making can be exercised. I do, however, continue to have difficulty in understanding why there cannot be two intended beneficiaries, especially if the statute is designed to benefit one (the providers) in order to provide the desired level of services to the other (the recipients).

Further, I suggest that the fact that the language post-repeal of Boren continues to reference "rates" is actually quite insignificant. In repealing Boren, Congress replaced the standard for the rates ("reasonable and adequate") with the requirement that the state provide for a public process for determination of rates. What is significant, however, is the fact that the Boren Amendment language that had been held to afford a cause of action required that rates be "reasonable and adequate," and the language we are quibbling over similarly describes a standard for payments to providers. I see no meaningful distinction between the two and therefore respectfully dissent.

A True Copy:
Teste:

Clerk of the United States Court of Appeals
for the Third Circuit

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

PENNSYLVANIA PHARMACISTS ASSOCIATION, et al.,	:	CIVIL ACTION
	:	NO. 99-491
Plaintiffs,	:	
v.	:	
FEATHER O. HOUSTOUN,	:	
Defendant.	:	

ORDER

AND NOW, this 7th day of June, 2000, upon consideration of Plaintiffs' Motion for Summary Judgment (Docket No. 48), and the Defendant's Response thereto (Docket No. 51), as well as Defendant's Motion for Summary Judgment (Docket No. 49) and Plaintiffs' Response (Docket No. 50); it is hereby **ORDERED** that the Plaintiffs' Motion is **DENIED** and the Defendant's Motion is **GRANTED**. Judgment is entered in favor of defendant and against all plaintiffs.

This case shall be marked **CLOSED** for statistical purposes.

BY THE COURT:

/s/ Ronald L. Buckwalter, J.
RONALD L. BUCKWALTER, J.

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

PENNSYLVANIA PHARMACISTS ASSOCIATION; et al.,	:	CIVIL ACTION
Plaintiffs,	:	NO. 99-491
v.	:	(Filed June 7, 2000)
FEATHER O. HOUSTOUN,	:	
Defendant.	:	

MEMORANDUM

BUCKWALTER, J. June 7, 2000

Presently before the Court are the Plaintiffs' and Defendant's Motions for Summary Judgment. After oral argument on May 25, 2000, and consideration of all briefs filed, for the reasons discussed below, the Defendant's Motion is Granted and the Plaintiffs' Motion is Denied.

I. BACKGROUND

Pennsylvania Pharmacists Association ("PPA") and sixteen individual pharmacies ("Named Pharmacy Plaintiffs"), collectively, ("Plaintiffs") have brought this class action pursuant to 42 U.S.C. §§ 1983 and 1988 against Feather O. Houstoun, the Secretary of the Pennsylvania Department of Public Welfare ("Department"). Plaintiffs seek various forms of relief, including a declaration that the outpatient pharmacy rates implemented under a managed-care program known as HealthChoices after February 1, 1997, were implemented in violation of federal law, the HealthChoices waiver, and pharmacies' Medical

Assistance provider agreements. In addition, Plaintiffs seek to enjoin the Defendant from permitting continued reimbursement of providers under the HealthChoices program using the current outpatient pharmacy rates and directing Defendant to require reimbursement under the same rates as pharmacies being reimbursed under the Medical Assistance fee-for-service program. Finally, Plaintiffs seek attorneys' fees and costs.

PPA is a Pennsylvania non-profit corporation representing over 440 independent pharmacies and over 1,000 pharmacists employed at these facilities. The Named Pharmacy Plaintiffs are independent pharmacies operating in Southeastern Pennsylvania. Plaintiffs represent a class of all pharmacies (not only the independent pharmacies that are members of PPA) participating in Pennsylvania's Medical Assistance Program and serving Medical Assistance Beneficiaries ("MABs") under Title XIX of the Social Security Act, 42 U.S.C. § 1396-1396v, in the counties of Bucks, Chester, Delaware, Montgomery, and Philadelphia (the "Five County Area").

To participate in the program, the Named Pharmacy Plaintiffs entered into standard provider agreements ("Agreements") with the Department, which cover the provision of brand-name and generic prescription drugs to eligible beneficiaries. Under the Agreements, the Department is obligated to insure that the Named Pharmacy Plaintiffs are reimbursed in accordance with state and federal law.

On December 31, 1996, the Department secured a waiver, effective February 1, 1997, from the United States Department of Health and Human Services, Health Care

Financing Administration ("HCFA") to certain provisions of the Social Security Act[1] in order to implement Pennsylvania's Medicaid Managed Care Program called HealthChoices.[2] Pursuant to the waiver, the Department contracted with four health maintenance organizations ("HMOs")[3] to administer the HealthChoices Program. These HMOs then subcontracted with pharmacy benefits managers to administer the outpatient pharmacy benefit under the respective HealthChoices Plan. The pharmacy benefits managers in turn contracted directly with participating pharmacies, including Plaintiffs, to provide outpatient pharmacy services to beneficiaries in the Five County Area. The basis of Plaintiffs' complaint is that the pharmacy benefits managers, without oversight from the Department, systematically decreased the outpatient pharmacy benefit rates to unreasonably low levels and that the Department's method of implementing the

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[1] The waiver from the HCFA applies to the following sections of Title XIX: Section 1902(a)(1), 42 U.S.C. § 1396a(a)(1), relating to state wideness; Section 1902(a)(10)(B), 42 U.S.C. § 1396a(a)(10)(B), relating to comparability of services; and Section 1902(a)(23), 42 U.S.C. § 1396a(a)(23), relating to freedom of choice.

[2] The Medicaid managed care program now administered in the five county area described above is now called "HealthChoices Southeast" to distinguish it from a similar program operating in the southwestern portion of Pennsylvania ("HealthChoices Southwest").

[3] The four HMOs are Keystone Mercy Health Plan ("Keystone"), Health Partners, Healthcare Management Alternatives, Inc. ("HMA") and Oxford Health Plans (now known as Oaktree Health Plan) ("Oaktree").

HealthChoices program to permit this result violated the waiver, the Agreements, and applicable federal law.

Specifically, Plaintiffs allege that the outpatient pharmacy rates are now set below the cost of acquisition and the cost of dispensing drugs that Named Pharmacy Plaintiffs supply to MABs enrolled in HealthChoices. They contend that this has resulted in a situation that is inconsistent with efficiency, economy, and quality of care and has decreased MABs' access to retail pharmacies under HealthChoices in violation of the Social Security Act, specifically § 1902(a)(30)(A), 42 U.S.C. § 1396a(a)(30)(A) ("Section 30(A)")[4]. Section 30(A) provides that a state plan for medical assistance must:

> provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan . . . as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.

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[4] The Supreme Court has found that medical providers can be the beneficiaries of parts of the Medicaid Act. *See Wilder v. Virginia Hospital Association*, 496 U.S. 498, 110 S.Ct. 2510 (1990) (in the context of the Boren Amendment). At least one Circuit Court has extended this to the equal access provision that is central to this case. *See Arkansas Medical Society v. Reynolds*, 6 F.3d 519, 526 (8th Cir. 1993).

In addition, the regulation at 42 C.F.R. § 431.12, which was adopted pursuant to § 1902(a)(4), 42 U.S.C. § 1396a(a)(4) ("Section (a)(4)"), requires a state plan to provide for a medical care advisory committee that must have the opportunity to participate in policy development and program administration. Plaintiffs assert that the Department has failed to comply with this regulation as well.

II. LEGAL STANDARD

Under Federal Rule of Civil Procedure 56(c), the test is whether there is a genuine issue of material fact and, if not, whether the moving party is entitled to judgment as a matter of law. *Gray v. York Newspapers, Inc.*, 957 F.2d 1070, 1078 (3d Cir. 1992). In evaluating a summary judgment motion, the court may examine the pleadings and other material offered by the parties to determine if there is a genuine issue of material fact to be tried. Fed.R.Civ.P. 56(c); *see also Celotex Corp. v. Catrett*, 477 U.S. 317, 322-23 (1986). When considering a motion for summary judgment, a court must view all evidence in favor of the nonmoving party. *See Bixler v. Central Pa. Teamsters Health and Welfare Fund*, 12 F.3d 1292, 1297 (3d Cir. 1993).

A movant "bears the initial responsibility of informing the court of the basis for its motion, and identifying those portions of the pleadings, depositions, answers to interrogatories, and admissions on file, together with affidavits, if any which it believes demonstrate the absence of a genuine issue of material fact". *Celotex*, 477 U.S. at 323. When movants do not bear the burden of persuasion at trial, they need only point to the court "that there is an

absence of evidence to support the nonmoving party's case. *Id.* at 325. A fact is material if it might affect the outcome of the suit under the governing substantive law. *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 255 (1986). For the dispute over the material fact to be genuine, "the evidence must be such that a reasonable jury could return a verdict in favor of the non-moving party." *Id.* To successfully challenge a motion for summary judgment, the non-moving party cannot merely rely upon the allegations contained in the complaint, but must offer specific facts contradicting the movant's assertion that no genuine issue is in dispute. *Kline v. First West Government Securities*, 24 F.3d 480, 485 (3d Cir. 1994).

III. DISCUSSION

A. Was the Procedure used by the Department when formulating the HealthChoices reimbursement scheme Department used Arbitrary and Capricious?

The Third Circuit has recently decided that § 30(A) does not require any particular methodology for satisfying the substantive requirements of a modified state Medicaid plan. *See Rite Aid v. Houstoun*, 171 F.3d 842, 851 (3d Cir. 1999). However, since a state may not act in an arbitrary and capricious manner, the state must have some objective basis by which it determines Medicaid reimbursement rates. *Id.* It is the responsibility of this Court then, to determine whether the Department has acted in an arbitrary and capricious manner in setting its reimbursement rates in the HealthChoices Southeast geographic area.

The Court may find that an action is arbitrary and capricious if the Department relied on factors other than those intended by Congress, did not consider "an important aspect" of the issue confronting the agency, provided an explanation for its decision which "runs counter to the evidence before the agency," or is entirely implausible. *See Motor Vehicle Mfrs. Ass'n of U.S., Inc. v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43, 103 S.Ct. 2856, 2867 (1983). The scope of review is narrow as the Court should uphold the Department's decision of less than ideal clarity if the Department's path may reasonably be discerned. *Id.* at 43, 103 S.Ct. at 2867.

The Department, in formulating payments and methods to be used in the Medicaid Program, must consider whether payments are consistent with efficiency, economy, quality of care and access to services, although it need not consider every factor to the same degree. *Rite Aid*, 171 F.3d at 851-853.

(1) Access to Services

The Department's procedure for deciding whether MABs had sufficient access to services was not arbitrary. The Department considered information from "other states" concerning reasonable "access provisions" and established a policy requirement that each HealthChoices HMO have available at least two participating pharmacies within 30 minutes travel time in urban areas, or within 60 minutes travel time in rural areas, via public or county transportation services (the "30/60 Standard"). (Def. Br. at 8). The Department developed the 30/60 Standard after reviewing its own data and that of other

states who had received HCFA approval for modifications of their Medicaid plans. Standards similar to the 30/60 Standard have been considered favorably by HCFA.[5] The Department continued to consider access when the HealthChoices HMOs lowered their pharmacy reimbursement rates in 1998 and 1999. It regularly receives lists of providers and maps showing provider access from the four HMOs.

The Plaintiffs point out that the 30/60 Standard was made without serious consideration of whether HealthChoices participants would have access to services at least to the same extent as those within the same geographic area with private insurance. It is certainly not clear whether the Department's methodology considered whether MABs would have access to services to the same extent as would the general population of the Five

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[5] *See* 63 Fed. Reg. 52,043 (proposed September 29, 1998).

"In proposing § 438.306(d)(1)(v), we recognize that standards vary across states with regard to geographic access. Some state agencies contracting with MCOs have established maximum travel and distance times that include *a 30-minute travel time standard*. Other states have established alternative standards such as a 10-30 mile travel distance, depending on the local terrain. *Both are examples of geographic access standards that would comply with this provision.* For instance, a state agency could require that all primary care services and commonly used specialty and referral services be available within 30 minutes driving time or bus time from any point in the service area, *with possible exceptions for certain rural areas or other low-population/low-density* areas where residents customarily travel greater distances to obtain specialty and referral services".

County Area.[6] Nevertheless, the Department did not disregard the access issue. Therefore, even if the Department's approach led to substantive inequalities, which will be determined below, the Court can not find that its consideration of "access" was arbitrary and capricious.

(2) Quality Pharmacy Services

The Department also contends that it properly considered the quality of the services provided by the HealthChoices HMO before its implementation and subsequent lowering of reimbursement rates. It requires that all contracting pharmacies comply with federal and state pharmacy law. The Department also monitors pharmacies to insure that HealthChoices members receive the same quality services that other pharmacy customers do. The Court finds the Department did not act arbitrarily when considering quality of services that would be provided under the HealthChoices program.

(3) Economy and Efficiency

The Plaintiffs, like the district court in *Rite Aid*, contend that the Department's price survey and analysis failed to properly consider efficiency and economy. The Third Circuit has found that using comparative data from

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[6] The district court in *Rite Aid* did not address the "access issue" when declining to hold that the Department had acted arbitrarily and capriciously. However, as the Third Circuit noted, the standard of access by which a program is judged is not absolute access, but the access to services relative to the general population. *See Rite Aid*, 171 F.3d at 854, n. 13.

third party payers and other states shows that the Department has made a reasonable effort to anticipate the effects of its actions. *Rite Aid*, 171 F.3d at 855. The Department followed similar methods to those which were challenged, but found not to be arbitrary and capricious, in formulating prices under the Fee-for-Service program. *Id.* The factors the Department used in this case to determine efficiency included the rates paid by private health plans. The Court understands Plaintiffs' contention that the Department's analysis is flawed. However, using the arbitrary and capricious standard for evaluating the Department's methodology as outlined in *Rite Aid*, the Court can not find as a matter of law that the Department procedurally violated 30(A).

B. Does HealthChoices's Reimbursement Schedule Substantively Violate 30(A)?

The Third Circuit in *Rite Aid* was not asked to determine whether the Department had substantively violated provisions of § 30(A). In this case, the Plaintiffs allege that the Department has substantively violated Section 30(A). The Court has found that the Department did not act arbitrarily in establishing the HealthChoices reimbursement schedule. However, the Department will still be liable if its policies have fallen short of the requirements of § 30(A).

The Plaintiffs claim that there are two distinct substantive rights under § 30(A): the right to require a State Medicaid program to use reimbursement "methods and procedures" which (1) will "safeguard against unnecessary utilization of such [medical] care and services and

assure that payments are consistent with efficiency, economy, and quality of care," and (2) are "sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area". *See Visiting Nurse Ass'n v. Bullen*, 93 F.3d 997, 1003 (1st Cir. 1996). In other words, the Department must be both economical and efficient, while insuring that MABs receive quality service and access equal to that of the general population.

The Plaintiffs have spent a good deal of time arguing that the reimbursement rates are too low. They provide evidence suggesting that the rates are not reasonable and adequate.[7] According to Plaintiffs, the statute's requirement that there is a reasonable rate at which they are entitled to be reimbursed is supported by the case law. *See Orthopaedic Hospital v. Belshe*, 103 F.3d 1491, 1499 (9th Cir. 1997) (For payment rates to be consistent with efficiency, economy, quality of care and access, they must bear a reasonable relationship to provider costs, unless

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[7] Under the provisions of the now-repealed Boren Amendment ("former § 13(A)"), the "right" asserted by Plaintiffs was more apparent. The Boren Amendment required the Department to set inpatient reimbursement rates that "the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services . . . and to assure that individuals eligible for medical assistance have reasonable access. . . .

there is some justification for rates that do not substantially reimburse providers their costs).[8]

However, the Court finds that an independent conclusion concerning whether the rates are reasonable or adequate is not necessary to decide whether the Department is in compliance with § 30(A). The Court understands that certain courts outside this Circuit have found a substantive requirement within § 30(A) that essentially incorporated the substantive requirement of adequate and reasonable from the Boren Amendment. *See e.g Moody Emergency Services v. City of Millbrook*, 967 F.Supp. 488, 493 (M.D. Ala. 1997); *Sobky v. Smoley*, 855 F.Supp. 1123 (E.D. Ca. 1994). To the extent that these cases are on point, though, they seem to rely on the spirit of the Boren Amendment. The Boren Amendment has, of course, been repealed. "With the repeal of the Boren Amendment nothing remains that remotely resembles a federal right to reasonable and adequate rates." *See Children's Seashore Hospital v. Waldman*, 197 F.3d 654, 659 (3d Cir. 1999) *quoting HCMF Corp. v. Gilmore*, 26 F.Supp.2d 873, 880 (W.D. Va. 1998). Plaintiffs correctly point out that the issue in *Waldman* concerned plaintiffs attempt to seek redress under § 13(A) rather than § 30(A). However, there is no reason to assume that the Third Circuit's holding would not equally apply under § 30(A). The Third Circuit does not appear to have ever adopted a standard that

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[8] The Ninth Circuit noted that § 30(A) was more flexible than the Boren Amendment (former § 13A). Although the court recognized that § 30(A) did not have explicit "reasonable and adequate" language, it held that the same requirement could be incorporated into § 30(A) by means of insuring that payment rates bear a reasonable relationship to provider costs.

required reimbursement rates to be adequate and reasonable under the efficiency and economy language of § 30(A). While the language of *Rite Aid* refers only to procedural requirements that are no longer required, the Third Circuit in both *Waldman* and *Rite Aid* indicates that Congress has signaled a change away from requirements towards results. Therefore, the Court declines to adopt a standard that requires an independent conclusion concerning the adequacy of reimbursement rates to Plaintiffs under the efficiency and economy provisions of § 30(A).

The state's desire to save costs by using managed care can only be commensurate with the necessity of being economical and efficient. The Plaintiffs have not argued that the quality of care provided to Medicaid recipients has suffered as a result of the Department's methods and procedures, or that they have fostered the unnecessary utilization of medical resources. However, the payments made by the Department must still be sufficient to enlist an adequate number of providers. The most relevant consideration is whether MABs have access to care and services to the same extent as the general population within the same geographic area. If the Plaintiffs can show that access "to the same extent" is not available, then the reimbursement plan approved by the Department will likely be in violation of § 30(A).[9]

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[9] In other words, it is premature to decide whether the reimbursement rate paid by the HealthChoices HMO's are adequate in a sense that they allow pharmacists a fair profit. The real issue presented here is whether the pay is sufficient to provide MABs with equal access. If the MABs have "equal access", then the Court will assume that payments are sufficient to maintain equal access. Then, plaintiffs will have to seek redress for the allegedly low payments elsewhere.

Therefore, the Court must find whether MABs in the HealthChoices HMOs have similar access to pharmacy services as are available to the general population of the Five County Area.

(1) Equal Access

The general population to which Medicaid access is compared is the access of other individuals in the same geographic area with private or public insurance coverage. *See Arkansas Medical Society, Inc. v. Reynolds*, 6 F.3d 519, 526 (8th Cir. 1993). Therefore, the Court must compare the access to care and services, including pharmacies, that HealthChoices members have compared to other individuals within the Five County Area. The Department recognizes that the waiver under which the HealthChoices program was implemented does not modify this responsibility, at least with regard to access to prescription drugs. However, there does not seem to be any accepted standard for determining access to services.[10]

One method for determining whether MABs have access to the same extent as privately insured individuals

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[10] For purposes of this discussion: services will be considered access to pharmacies. Although Plaintiffs state that the Department did not consider access to pharmacies in establishing the 30/60 Standard (access to primary service providers was the foremost consideration), the Department testifies that the 30/60 Standard is used by the Department to judge whether the HealthChoices HMO networks are maintaining their contractual duties.

would be to count the number of pharmacies participating in the HealthChoices network compared to the number of overall pharmacies in the Five County Area. But it is indisputable that not every pharmacy participates in the HealthChoices network. Therefore, it would be an impossible standard for the Department to satisfy, as it would likely be for any state in which at least some pharmacies do not accept Medicaid reimbursed prescriptions. A second method would be to determine the average distance a privately insured individual must travel to get to a pharmacy and compare that to the distance the average MAB must travel.[11] This second standard was used by the Department, although it is not clear whether it was established after determining the distance for the average privately insured person.[12]

A third method of comparison is to measure the access of the average privately insured person, based on healthcare realities, compared to a MAB enrolled in one of the Healthcare HMOs. The average privately insured person does not have access to every pharmacy in the Five County Area. A member of the general population

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[11] The HCFA regulations support this approach. HCFA encourages state agencies to consider "distance, travel time, and the means of transportation normally used". Also, "the assessment of capacity necessarily should consider the volume of service being provided to patients other than MCO enrollees". *See* 63 Fed. Reg. 52,042 (proposed September 29, 1998).

[12] The Department claimed that it developed the standard based on information from "other states". However, it fails to explain whether access in other states was based on distance and/or travel time to pharmacies.

likely belongs to either an HMO or a medical plan that allows her to fill prescriptions only at certain pharmacies. Using this method, the Department draws comparisons between the number of pharmacies accessible to a privately-insured Independence Blue Cross ("IBC") plan member and those available to a person using the Keystone plan through HealthChoices.[13] The Plaintiffs seem to favor an absolute standard, where if a cash customer can pay, a Medicaid beneficiary should be able to receive services as well.[14] Neither side provides case law to help determine what the proper access standard under § 30(A) should be. The Court favors a standard that compares accessibility for MABs and privately insureds by travel time and distance as well as total number of pharmacies available. After reviewing the evidence provided by both parties, the Court was able to make certain findings, as well as discount certain contentions made by the various parties.

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[13] The number of participating pharmacies in each plan has varied, but as of April 1, 2000 there are:

1)	IBC:	963 serving 1,900,000 members
2)	Oaktree:	864 serving 56,000 members
3)	Keystone:	794 serving 220,000
4)	HMA:	635 serving 73,000 members
5)	Heath Partners:	600 serving 113,000 members

[14] Plaintiff encourages the Court to use a high standard to measure access; that of the Medicaid fee for service patient, who presumably could have prescriptions filled at any pharmacy. But this high standard is not likely to be the equivalent of access to services available to the general population. Also, the HCFA regulations state only that a member of HealthChoices should not have to travel an *unreasonable distance beyond* what is customary in a Medicaid fee-for-service arrangement. *See* 63 Fed. Reg. 52,042 (proposed September 29, 1998).

The Department stipulates that, as of February, 1997, there were 1,192 pharmacies within the Five County Area participating in the pre-HealthChoices fee-for-service Medicaid program[15]. Today there are approximately 800-900 participating pharmacies in the Oaktree and Keystone plans, which are the two largest of the HealthChoices HMOs in terms of pharmacy participation. Therefore, if one were a present HealthChoices Oaktree member, one would have access to approximately 25% less pharmacies than prior to the HealthChoices. The Court might have found this decrease significant if it were the only standard by which access could be judged. But a decrease does not necessarily lead to access below that of the general insured population. The Plaintiffs have demonstrated a decrease in the number of independent pharmacies. However, the closure of a pharmacy would limit access for both MABs and privately insureds. It would be more significant if the pharmacy continued to function but stopped dispensing Medicaid prescriptions.

The general population does not have access to every pharmacy in the Five County Area. A typical medical consumer's choices are limited by the HMO, or medical plan, to which he belongs. Relatively few individuals have access to the equivalent of a fee for service plan. In any event, the Court can not claim that the Department

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[15] It can be presumed that not all of these pharmacies exist today. However, neither party has directed the Court's attention to the total number of pharmacies that are in business today or were in business in January, 1997. For illustration purposes, the Court will assume that the 1192 represented all possible pharmacy locations in the Five County Area at the time of the HealthChoices implementation.

has violated the access provisions of § 30(A) merely because there might be a pharmacy that some privately insured person would have access to that a Medicaid recipient would not. Assuming that the 1192 pharmacies that participated in the fee for service program represented all of the pharmacies in the Five County Area, then a privately insured person enrolled in IBC would not have access to prescriptions at approximately 230 pharmacies (or 20% less pharmacies than would an individual using a fee for service plan). This is not a significant disparity in access.

Plaintiffs use IBC access as the standard for a privately insured person. They then compare the number of participating pharmacies accessible to IBC members to the number available to members of HMA and Health Partners. Since the number available to members of these two HealthChoices HMOs are approximately 300 less than the number available to members of IBC, the Plaintiffs conclude that access for Medicaid recipients is significantly less than for private individuals. However, the access situation would be reversed if one were to use as the standard a private insurer that had significantly less available pharmacies (approximately 600) compared to IBC (950+). Then, if the number of Oaktree or Keystone available pharmacies were used as the MAB accessible standard, the MABs would actually have greater comparative access.

The Defendant has also provided evidence showing that between August, 1998 and April, 1999, the number of participating pharmacies in the Health Partners Network increased throughout the five county area from 403 to 541 (as of April 1, 2000 the number is 600 pharmacies). This is

a 34% increase and the number of pharmacies increased fairly proportionally throughout the five counties.

It is true that the Department was concerned that the number of participating pharmacies in the Keystone network would decrease by approximately 50% upon implementation of EMC as the pharmacy benefits manager for Keystone in 1998 (and the subsequent reduction of reimbursement rates). However, today there are over 800 participating pharmacists in the Keystone plan. The letter from Vivienne Bowser of August 1998 to Health Partners is similar to the letter sent in April, 1998 to Keystone. It mentions the Department's concern that pharmacists are leaving the network, but there is no mention of a 50% decrease in available pharmacies. But as discussed above, the expected decrease did not materialize to any great extent, and by April, 2000, Health Partners had increased its pharmacy participation rate by almost 50% since August, 1998.

The Plaintiffs claim that access "to the same extent", is denied MABs in Northern Bucks County because there are two pharmacies that exist, but do not belong to either the HMA, Oaktree or Health Partners network. The Plaintiff does not provide information about whether the pharmacies participate in the Keystone HMO network, but the Court will assume that they do not. The documents cited by Plaintiff give no indication of why these particular pharmacies do not participate in HealthChoices. Also, the Plaintiffs use a cash paying customer as the "general population" standard for judging Medicaid beneficiary access. The Court has already expressed its wariness concerning the appropriateness of this standard considering the fact that so many individuals today participate in

non-Medicaid managed care plans. Plaintiffs fail to demonstrate that the average privately insured individual, such as an IBC member, would have access to these two facilities.[16]

The Court will also look, as the Department did, at comparative access in terms of travel time. There does not seem to be any evidence provided concerning travel time prior to February, 1997 for MABs compared with the general population. But the Department has provided some evidence of present travel time for MABs. In Bucks County, the area of greatest concern for the Plaintiffs, 92% of Keystone members were within three miles of a pharmacy provider, while 98% were within five miles. In Chester, the numbers are 66% and 89% respectively. These numbers definitely seem "reasonable distances" to travel to obtain necessary prescriptions. "Reasonable distance", however, is not the absolute standard by which access is to be judged. Plaintiffs ha[ve] the burden of showing access is not equal. They have not provided any information concerning the privately insured population's average distance from a participating pharmacy in Northern Bucks County or Northwestern Chester County. Therefore, since the Plaintiffs have failed to meet their burden of showing that access for MABs in the Five County Area is not available to the same extent as it is for private insureds, summary judgment will be entered for the Defendant.

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[16] It is possible that MABs in these rural parts of Chester and Bucks may have more convenient access to pharmacies in Lancaster and Northampton Counties.

C. Did the Department fail to comply with the MAAC and publication requirements of the Medicaid Act?

The Plaintiffs also claim that the Department violated § 1902(a)(4) of the Act by failing to meet with the Medical Assistance Advisory Committee ("MAAC") before allowing reimbursement rates to be lowered by the HealthChoices HMOs. According to the implementing regulation of § 1902(a)(4), the MAAC "must have opportunity for participation in policy development and program administration". *See* 42 C.F.R. § 431.12. Although it is not clear how far the Department's duty stretches to give MAAC the "opportunity to participate", the Third Circuit has held that the Department must consult with the MAAC prior to final HCFA approval of a plan amendment. *See Rite Aid*, 171 F.3d at 856. It is undisputed that the Department met with the MAAC prior to the final approval of HealthChoices by HCFA. The Court need not decide whether § 431.12 requires the Department to consult with the MAAC whenever the HealthChoices HMOs lower reimbursement rates. Assuming that such consultation is necessary, the Department has violated the requirement. However, this does not require the Court to issue an injunction against the HealthChoices program. *Id.* at 856-857 (holding that Department's violation of § 431.12 was not grounds for an injunction and reversing the district court's grant). The Court likewise finds that the Department's probable violation of § 431.12 does not warrant an injunction.

The Department also has a duty to give public notice of changes in Statewide methods and standards for

setting payment rates. *See* 42 C.F.R. § 447.205. This Regulation requires that notice of the change be published before the proposed effective date in either the *Pennsylvania Bulletin*, or a major newspaper, and must "describe the proposed change. . . . explain why the agency is changing its methods and standards. . . . and give an address where written comments may be sent and reviewed by the public". *Id.* The Court agrees with the Defendant that the Regulation only places a duty of public notice when a statewide practice of the Department is changed. The HealthChoices Southeast HMOs' reimbursement rates apply only within the Five County Area.[17] Also, as the Department argues, it did not change any policy when the HMOs lowered reimbursement rates.[18] These reductions were instituted by the HMOs themselves and were consistent with already approved contracts and the waiver granted by HCFA. The Court finds, therefore, that the Department did not violate [its] duty under § 447.205.

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[17] On the record, there is no evidence of whether the four HMOs participate in HealthChoices Southwest (in Western Pennsylvania), and if they do, whether the reimbursement rates in that program are the same as those paid to pharmacists in the HealthChoices Southeast region. Also, clearly these rates do not apply in those parts of the Commonwealth that do not fall under either HealthChoices program.

[18] The Third Circuit found that the Department did have a public notice duty when it changed its reimbursement schedule for the fee for service program prior to the implementation of HealthChoices. *See Rite Aid*, 171 F.3d at 857. But in that case, the Department itself was changing the reimbursement rate and these changes were to have effect throughout the Commonwealth.

IV. CONCLUSION

Pennsylvania's Medicaid program presents the Department with great challenges. The Department instituted HealthChoices as a means of furthering the program's efficiency and economy, while maintaining quality services and access for MABs. Plaintiffs have produced evidence that suggests it has become increasingly difficult for pharmacists, especially independent pharmacists, to run profitable businesses. But they have failed to demonstrate that the Department has violated the Medicaid Act. Therefore, summary judgment will be granted in favor of the Department and against Plaintiffs.

An appropriate Order follows.

Filed July 20, 2001

UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

No. 00-1898

PENNSYLVANIA PHARMACISTS ASSOCIATION; BELL EDGE PHARMACY; BROAD STREET APOTHECARY; BURNS' PHARMACY; CAMBRIA PHARMACY #3; CHRISTIAN STREET PHARMACY; ELWYN PHARMACY; ESTERSON PHARMACY; FOSTERS PHARMACY; GETWELL PHARMACY; MCKEAN STREET PHARMACY; ROSICA PHARMACY; S&S COMMUNITY DRUG, INC.; SILVERMAN PHARMACY; TIOGA DRUG COMPANY; WELDON PHARMACY, and other similarly Situated Pharmacies; TIRELLI, INC., dba BROAD STREET APOTHECARY; ROBERT SCHREIBER, dba BURNS' PHARMACY; CAMBRIA PHARMACIES, INC.; BARRY JACOBS, dba ELWYN PHARMACY; 2401 EAST YORK STREET, INC., dba ESTERSON'S PHARMACY; RIAZ U. RAHMAN, dba GETWELL PHARMACY; FOSTER PHARMACY, INC.; HAUSSMANN'S PHARMACY; MCKEAN STREET PHARMACY, INC.; THOMAS BETTERIDGE, dba ROSICA PHARMACY; WELDON PHARMACY, INC.

Appellants

v.

FEATHER O. HOUSTOUN
(D.C. Civ. No. 99-cv-00491)

Argued: April 20, 2001

Before: ALITO, McKEE, and ALARCON,*
Circuit Judges.

Present: BECKER, *Chief Judge*, MANSMANN, NYGAARD, ALITO, ROTH, McKEE, RENDELL, BARRY, AMBRO, and FUENTES, *Circuit Judges.*

AMENDED ORDER

A majority of the active judges, who are not recused, having voted for hearing *en banc* in the above appeal, it is ORDERED that the Clerk of this Court list the above case for hearing *en banc* at the convenience of the Court.

BY THE COURT.

/s/ Edward R. Becker
Chief Judge

DATED: July 20, 2001

A True Copy:
Teste:

Clerk of the United States Court of Appeals
for the Third Circuit

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* Honorable Arthur L. Alarcon, United States Circuit Judge for the Ninth Circuit, sitting by designation.

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

PENNSYLVANIA PHARMACISTS ASSOCIATION, *et al.*,

Plaintiffs,

v.

FEATHER O. HOUSTOUN,

Defendant.

CIVIL ACTION

NO. 99-491

(Filed Jul. 22, 1999)

ORDER

AND NOW this 22 day of July 1999, upon consideration of Defendant's Motion to Dismiss the Second Amended Complaint or, in the Alternative, Motion to Stay Action Pending the Outcome of Plaintiffs' Parallel State Action (Docket No. 21), Plaintiffs' Memorandum in Opposition thereto (Docket No. 22), Defendant's Reply (Docket No. 23), Plaintiffs' Sur-Reply (Docket No. 24), Defendant's Sur-Sur-Reply (Docket No. 28), and Plaintiffs' Supplemental Memorandum (Docket No. 30), it is hereby **ORDERED** that Defendant's motion is **DENIED** in its entirety.

The Court concludes that Plaintiffs have an enforceable right to challenge Defendant's administration of the HealthChoices waiver. *See Pennsylvania Pharmacists Ass'n, et al. v. Commonwealth of Pa. Dep't of Pub. Welfare*, No. 928 M.D. 1998, at 7-8 (Pa. Commw. June 11, 1999). Plaintiffs also have a private right to enforce 42 U.S.C. § 1396a(a)(30)(A), and regulation 42 C.F.R. § 431.12, which was promulgated pursuant to 42 U.S.C.

§ 1396a(a)(4). *See Rite Aid of Pa., Inc. v. Houston*, 171 F.3d 842, 849 nn.7 & 14 (3d Cir. 1999).

The Court further concludes that there are no facts in this case that would warrant abstention.

BY THE COURT:

/s/ Ronald L. Buckwalter, J.